

By: Marchant

H.B. No. 2922

A BILL TO BE ENTITLED

AN ACT

relating to a nonsubstantive revision of statutes relating to the Texas Department of Insurance, the business of insurance, and certain related businesses, including conforming amendments, repeals, and penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. TITLE 3, INSURANCE CODE. The Insurance Code is amended by adding Title 3 to read as follows:

TITLE 3. DEPARTMENT FUNDS, FEES, AND TAXES

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 201. COLLECTION OF REVENUE AND ADMINISTRATION
OF FUNDS

CHAPTER 202. FEES

CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

[Chapters 204-220 reserved for expansion]

SUBTITLE B. INSURANCE PREMIUM TAXES

CHAPTER 221. PROPERTY AND CASUALTY INSURANCE PREMIUM TAX

CHAPTER 222. LIFE, HEALTH, AND ACCIDENT INSURANCE PREMIUM
TAX

CHAPTER 223. TITLE INSURANCE PREMIUM TAX

CHAPTER 224. RECIPROCAL AND INTERINSURANCE EXCHANGE
PREMIUM TAX

CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED

1 INSURANCE PREMIUM TAX
2 CHAPTER 227. DISPOSITION OF PROCEEDS OF CERTAIN PREMIUM
3 TAXES
4 [Chapters 228-250 reserved for expansion]
5 SUBTITLE C. INSURANCE MAINTENANCE TAXES
6 CHAPTER 251. GENERAL PROVISIONS
7 CHAPTER 252. FIRE AND ALLIED LINES INSURANCE
8 CHAPTER 253. CASUALTY INSURANCE AND FIDELITY, GUARANTY,
9 AND SURETY BOND INSURANCE
10 CHAPTER 254. MOTOR VEHICLE INSURANCE
11 CHAPTER 255. WORKERS' COMPENSATION INSURANCE
12 CHAPTER 256. AIRCRAFT INSURANCE
13 CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE
14 CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS
15 CHAPTER 259. THIRD-PARTY ADMINISTRATORS
16 CHAPTER 260. NONPROFIT LEGAL SERVICES CORPORATIONS
17 CHAPTER 261. TEXAS INSURANCE EXCHANGE
18 [Chapters 262-270 reserved for expansion]
19 SUBTITLE D. TITLE INSURANCE MAINTENANCE FEES
20 CHAPTER 271. TITLE INSURANCE MAINTENANCE FEES
21 [Chapters 272-280 reserved for expansion]
22 SUBTITLE E. OTHER TAXES
23 CHAPTER 281. RETALIATORY PROVISIONS
24 TITLE 3. DEPARTMENT FUNDS, FEES, AND TAXES
25 SUBTITLE A. GENERAL PROVISIONS
26 CHAPTER 201. COLLECTION OF REVENUE AND
27 ADMINISTRATION OF FUNDS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 201.001. TEXAS DEPARTMENT OF INSURANCE OPERATING
ACCOUNT

Sec. 201.002. ACCOUNTING PROCEDURE

Sec. 201.003. REFUNDS

Sec. 201.004. ELECTRONIC TRANSFERS

Sec. 201.005. TRANSFER OF SECURITIES

[Sections 201.006-201.050 reserved for expansion]

SUBCHAPTER B. ADMINISTRATION

Sec. 201.051. POWERS AND DUTIES OF COMPTROLLER

Sec. 201.052. REIMBURSEMENT

Sec. 201.053. COOPERATION BETWEEN DEPARTMENT AND
COMPTROLLER

Sec. 201.054. INFORMATION SHARING; FEDERAL IDENTIFICATION
NUMBERS

Sec. 201.055. FILING DATE OF REPORT OR PAYMENT DELIVERED BY
POSTAL SERVICE

CHAPTER 201. COLLECTION OF REVENUE AND ADMINISTRATION
OF FUNDS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 201.001. TEXAS DEPARTMENT OF INSURANCE OPERATING
ACCOUNT. (a) The Texas Department of Insurance operating account
is an account in the general revenue fund. The account includes the
following:

(1) taxes and fees received by the commissioner or
comptroller that are required by this code to be deposited to the
credit of the account; and

1 (2) money or credits received by the department or
2 commissioner from sales, reimbursements, and fees authorized by law
3 other than this code, including money or credits received from:

4 (A) charges for providing copies of public
5 information under Chapter 552, Government Code;

6 (B) the disposition of surplus or salvage
7 property under Subchapters C and D, Chapter 2175, Government Code;

8 (C) the sale of publications and other printed
9 material under Section 2052.301, Government Code;

10 (D) miscellaneous transactions and sources under
11 Section 403.011 or 403.012, Government Code;

12 (E) charges for postage spent to serve legal
13 process under Section 17.025, Civil Practice and Remedies Code;

14 (F) the comptroller involving warrants for which
15 payment is barred under Chapter 404, Government Code;

16 (G) sales or reimbursements authorized by the
17 General Appropriations Act; and

18 (H) the sale of property purchased with money
19 from the account or a predecessor fund or account.

20 (b) The commissioner shall administer money in the account
21 and may spend money from the account in accordance with state law,
22 rules adopted by the commissioner, and the General Appropriations
23 Act.

24 (c) Money deposited to the credit of the account may be used
25 for any purpose for which money in the account is authorized to be
26 used by law. (V.T.I.C. Art. 1.31A, Secs. 2, 3, 4, 5, 6(a).)

27 Sec. 201.002. ACCOUNTING PROCEDURE. The commissioner shall

1 maintain a procedure to account for the receipt, disbursement, and
2 allocation of money deposited in the Texas Department of Insurance
3 operating account, including recordkeeping procedures adequate
4 for:

5 (1) the commissioner or comptroller, as applicable, to
6 adjust the tax assessments and fee schedules as authorized by this
7 code; and

8 (2) the state auditor to determine the source of all
9 receipts and expenditures. (V.T.I.C. Art. 1.31A, Sec. 6(b).)

10 Sec. 201.003. REFUNDS. If the department determines that a
11 person, firm, or corporation through mistake of law or fact
12 erroneously paid or overpaid a fee or other amount of money,
13 including any interest or penalty, administered or collected by the
14 department, the department may refund the erroneous payment or
15 overpayment by warrant on the state treasury from any funds
16 appropriated for that purpose. (V.T.I.C. Art. 1.31.)

17 Sec. 201.004. ELECTRONIC TRANSFERS. (a) The commissioner
18 shall adopt rules for the electronic transfer of any fee, guarantee
19 fund, or other money owed to or held for the benefit of this state
20 that the department has the responsibility to administer under this
21 code or another insurance law of this state.

22 (b) The commissioner shall require the electronic transfer
23 of any amount held or owed that exceeds \$500,000. (V.T.I.C. Art.
24 1.10, Sec. 20.)

25 Sec. 201.005. TRANSFER OF SECURITIES. (a) A transfer by
26 the department of any security that is held in any way by the
27 department is not valid unless the transfer is countersigned by the

1 comptroller.

2 (b) The comptroller shall:

3 (1) countersign any security transfer presented by the
4 department;

5 (2) keep a record of all transfers that includes:

6 (A) the name of the transferee, unless the
7 security is transferred in blank; and

8 (B) a description of the security;

9 (3) when countersigning a security transfer, advise
10 the company concerned by mail of the details of the transaction; and

11 (4) state, in the comptroller's annual report to the
12 legislature, the countersigned transfers and the amount of the
13 transfers.

14 (c) To verify the correctness of records:

15 (1) the department is entitled to free access to the
16 comptroller's records kept under Subsection (b); and

17 (2) the comptroller is entitled to free access to the
18 books and other department documents relating to securities held by
19 the department. (V.T.I.C. Arts. 1.20, 1.21, 1.22.)

20 [Sections 201.006-201.050 reserved for expansion]

21 SUBCHAPTER B. ADMINISTRATION

22 Sec. 201.051. POWERS AND DUTIES OF COMPTROLLER. (a) Except
23 as otherwise provided by this code or another insurance law of this
24 state, the comptroller shall administer and enforce the provisions
25 of this code and other insurance laws of this state that relate to
26 the administration, collection, and reporting of taxes and certain
27 fees and assessments imposed under this code or another insurance

1 law of this state, as specifically provided by this code.

2 (b) The comptroller may:

3 (1) adopt rules to implement the administration,
4 collection, reporting, and enforcement responsibilities assigned
5 to the comptroller under this code or another insurance law of this
6 state; and

7 (2) prescribe appropriate report forms, establish or
8 alter tax report due dates not otherwise specifically prescribed by
9 this code or another insurance law of this state, and otherwise
10 adapt the functions transferred to the comptroller under Chapter
11 685, Acts of the 73rd Legislature, Regular Session, 1993, to
12 increase efficiency and cost-effectiveness.

13 (c) A rule adopted by the comptroller that relates to the
14 administration, collection, reporting, or enforcement of taxes
15 imposed under this code prevails over a conflicting rule, policy,
16 or procedure established by the department, the commissioner, or
17 otherwise.

18 (d) Subtitles A and B, Title 2, Tax Code, apply to the
19 administration, collection, and enforcement by the comptroller of
20 taxes and certain fees and assessments under this code or another
21 insurance law of this state. Except as otherwise provided by this
22 code, the powers granted to the comptroller under those provisions
23 of the Tax Code do not limit and are exclusive of the powers granted
24 to the department or the commissioner in relation to other fees and
25 assessments under this code. (V.T.I.C. Art. 1.04D, Secs. (a), (c),
26 (d).)

27 Sec. 201.052. REIMBURSEMENT. (a) The department shall

1 reimburse the appropriate portion of the general revenue fund for
2 the amount of expenses incurred by the comptroller in administering
3 taxes imposed under this code or another insurance law of this
4 state.

5 (b) The comptroller shall certify to the commissioner the
6 total amount of expenses estimated to be required to perform the
7 comptroller's duties under this code or another insurance law of
8 this state for each fiscal biennium. The comptroller shall provide
9 copies of the certification to the budget division of the
10 governor's office and to the Legislative Budget Board.

11 (c) The amount certified by the comptroller shall be
12 transferred from the Texas Department of Insurance operating
13 account to the appropriate portion of the general revenue fund. It
14 is the legislature's intent that money in the Texas Department of
15 Insurance operating account to be transferred under this subsection
16 should reflect the revenues from maintenance taxes paid by insurers
17 under this code or another insurance law of this state.

18 (d) In setting maintenance taxes for each fiscal year, the
19 commissioner shall ensure that the amount of taxes imposed is
20 sufficient to fully reimburse the appropriate portion of the
21 general revenue fund for the amount of expenses incurred by the
22 comptroller in administering taxes imposed under this code or
23 another insurance law of this state.

24 (e) If the amount of maintenance taxes collected is not
25 sufficient to reimburse the appropriate portion of the general
26 revenue fund for the amount of expenses incurred by the
27 comptroller, other money in the Texas Department of Insurance

1 operating account shall be used to reimburse the appropriate
2 portion of the general revenue fund. (V.T.I.C. Art. 4.19.)

3 Sec. 201.053. COOPERATION BETWEEN DEPARTMENT AND
4 COMPTROLLER. The commissioner and the comptroller shall cooperate
5 fully in performing their respective duties under this code or
6 another insurance law of this state. (V.T.I.C. Art. 4.18, Sec.
7 (a).)

8 Sec. 201.054. INFORMATION SHARING; FEDERAL IDENTIFICATION
9 NUMBERS. (a) The department shall comply with each reasonable
10 request from the comptroller relating to the sharing of information
11 gathered or compiled in connection with functions the comptroller
12 performs under this code or another insurance law of this state.

13 (b) The department shall maintain a record of the federal
14 identification number of each entity subject to regulation under
15 this code or another insurance law of this state and shall include
16 the appropriate number in any communication to or information
17 shared with the comptroller relating to that entity. (V.T.I.C.
18 Art. 4.18, Secs. (b), (c).)

19 Sec. 201.055. FILING DATE OF REPORT OR PAYMENT DELIVERED BY
20 POSTAL SERVICE. Except as otherwise specifically provided, for a
21 report, including a tax report, or payment that is required to be
22 filed or made in the offices of the comptroller and that is
23 delivered by the United States Postal Service to the offices of the
24 comptroller after the date on which the report or payment is
25 required to be filed or made, the date of filing or payment is the
26 date of:

27 (1) the postal service postmark stamped on the cover

1 in which the report or payment is mailed; or

2 (2) any other evidence of mailing authorized by the
3 postal service reflected on the cover in which the report or payment
4 is mailed. (V.T.I.C. Art. 1.11 (part), as amended Acts 77th Leg.,
5 R.S., Ch. 1419.)

6 CHAPTER 202. FEES

7 SUBCHAPTER A. GENERAL PROVISIONS

8 Sec. 202.001. APPLICABILITY OF CHAPTER

9 Sec. 202.002. DETERMINATION OF FEES

10 Sec. 202.003. FEES FOR COPIES

11 Sec. 202.004. REDUCED FEES FOR CERTAIN INSURERS

12 [Sections 202.005-202.050 reserved for expansion]

13 SUBCHAPTER B. SPECIFIC MAXIMUM FEES

14 Sec. 202.051. GENERAL FEES IMPOSED ON INSURERS

15 Sec. 202.052. FEES IMPOSED ON CERTAIN INSURERS

16 [Sections 202.053-202.100 reserved for expansion]

17 SUBCHAPTER C. DEPOSIT AND USE OF FEES

18 Sec. 202.101. DEPOSIT AND USE OF FEES GENERALLY

19 Sec. 202.102. DEPOSIT AND USE OF CERTAIN OTHER FEES

20 CHAPTER 202. FEES

21 SUBCHAPTER A. GENERAL PROVISIONS

22 Sec. 202.001. APPLICABILITY OF CHAPTER. Except as provided
23 by Section 202.052, the insurers that are subject to a fee imposed
24 under this chapter include:

- 25 (1) stock insurance companies;
26 (2) mutual insurance companies;
27 (3) local mutual aid associations;

1 (4) statewide mutual assessment companies;
2 (5) group hospital service corporations; and
3 (6) stipulated premium companies. (V.T.I.C. Art.
4 4.07, Sec. D.)

5 Sec. 202.002. DETERMINATION OF FEES. The department shall,
6 subject to the limits established by this chapter, set the amount of
7 the fees imposed under this chapter. (V.T.I.C. Art. 4.07, Secs. A
8 (part), C.)

9 Sec. 202.003. FEES FOR COPIES. (a) The department shall
10 set and collect a fee for copying any paper of record with the
11 department. The fee shall be set in an amount sufficient to
12 reimburse the state for the actual expense.

13 (b) The department may make and distribute copies of a paper
14 containing rating information without charge or for a fee that the
15 commissioner considers appropriate for administering the premium
16 rating laws by properly distributing rating information.

17 (c) This section does not affect Article 5.29. (V.T.I.C.
18 Art. 4.07, Sec. E.)

19 Sec. 202.004. REDUCED FEES FOR CERTAIN INSURERS. An
20 insurer to which this chapter applies that had gross premium
21 receipts of less than \$450,000, according to the insurer's annual
22 statement for the preceding year ending December 31, is required to
23 pay only one-half the amount of a fee otherwise required to be paid
24 under this chapter. (V.T.I.C. Art. 4.07, Sec. H.)

25 [Sections 202.005-202.050 reserved for expansion]

26 SUBCHAPTER B. SPECIFIC MAXIMUM FEES

27 Sec. 202.051. GENERAL FEES IMPOSED ON INSURERS. The

department shall impose and receive fees for the use of the state from each authorized insurer writing insurance in this state. The amount of the fees may not exceed:

- (1) for filing an amendment to a certificate of authority if the charter is not amended \$100;
- (2) for affixing the official seal and certifying to the seal \$20;
- (3) for reservation of name \$200;
- (4) for renewal of reservation of name \$50;
- (5) for filing an application for admission of a foreign or alien insurer \$4,000;
- (6) for filing an original charter of an insurer, including issuance of a certificate of authority \$3,000;
- (7) for filing an amendment to a charter if a hearing is held \$500;
- (8) for filing an amendment to a charter if a hearing is not held \$250;
- (9) for filing a designation of an attorney for service of process or an amendment of a designation \$50;
- (10) for filing a copy of a total reinsurance agreement \$1,500;
- (11) for filing a copy of a partial reinsurance agreement \$300;
- (12) for accepting a security deposit \$200;
- (13) for substitution or amendment of a security deposit \$100;
- (14) for certification of a statutory deposit . . \$20;

(15) for filing a notice of intent to locate books and records outside this state under Chapter 803 \$300;

(16) for filing a statement under Subchapters D and E, Chapter 823, for the first \$9.9 million of the consideration \$1,000;

(17) for filing a statement under Subchapters D and E, Chapter 823, if the amount of the consideration exceeds \$9.9 million an additional \$500 for each additional \$10 million of the consideration that exceeds \$9.9 million, but not more than a total amount of \$10,000 under this subdivision and Subdivision (16);

(18) for filing a registration statement under Subchapter B, Chapter 823 \$300;

(19) for filing for review under Subchapter C, Chapter 823, or Subchapter L, Chapter 884 \$500;

(20) for filing a direct reinsurance agreement under Subchapter K, Chapter 884 \$300;

(21) for filing for approval of a merger under Chapter 824 \$1,500;

(22) for filing for approval of reinsurance under Chapter 828 \$1,500;

(23) for filing restated articles of incorporation for a domestic, foreign, or alien insurer \$500;

(24) for filing a joint control agreement \$100;

(25) for filing a substitution or amendment to a joint control agreement \$40; and

(26) for filing a change of attorney in fact . . . \$500.

(V.T.I.C. Art. 4.07, Sec. A (part).)

Sec. 202.052. FEES IMPOSED ON CERTAIN INSURERS. (a) The department shall impose and the comptroller shall collect fees for the use of the state from each authorized insurer writing a class of insurance that may be written by an insurer operating under Chapter 841. The amount of the fees may not exceed:

(1) for valuing life insurance policies, and for each \$1 million of insurance or fraction thereof \$10; and

(2) for filing the annual statement \$500.

(b) Subtitles A and B, Title 2, Tax Code, apply to a fee collected under this section. (V.T.I.C. Art. 4.07, Sec. B.)

[Sections 202.053-202.100 reserved for expansion]

SUBCHAPTER C. DEPOSIT AND USE OF FEES

Sec. 202.101. DEPOSIT AND USE OF FEES GENERALLY. Amounts collected under Section 202.051:

(1) shall be deposited to the credit of the Texas Department of Insurance operating account; and

(2) may be appropriated only for the use and benefit of the department as provided by the General Appropriations Act to pay salaries and other expenses arising from and in connection with investigations of violations of the insurance laws of this state and the examination or licensing of insurers. (V.T.I.C. Art. 4.07, Sec. F.)

Sec. 202.102. DEPOSIT AND USE OF CERTAIN OTHER FEES. Amounts collected by the comptroller under Section 202.052:

(1) shall be deposited to the credit of the general revenue fund; and

(2) are available for appropriation to the department as provided by the General Appropriations Act to pay salaries and other expenses arising from investigations of violations of the insurance laws of this state and the examination or licensing of insurers. (V.T.I.C. Art. 4.07, Sec. G.)

CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

Sec. 203.001. LIMITATION ON CERTAIN ADDITIONAL TAXES

Sec. 203.002. TAX PAYMENT REQUIRED FOR CERTAIN CERTIFICATES;

UNREPORTED GROSS PREMIUM RECEIPTS

CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

Sec. 203.001. LIMITATION ON CERTAIN ADDITIONAL TAXES. (a)

This section applies to:

(1) an insurer authorized to engage in the business of insurance in this state other than an eligible surplus lines insurer; and

(2) a health maintenance organization authorized to engage in the business of a health maintenance organization in this state.

(b) Except as otherwise provided by this code or the Labor Code, an insurer or health maintenance organization subject to a tax imposed by Chapter 4, 221, 222, 224, or 257 may not be required to pay any additional tax imposed by this state or a county or municipality in proportion to the insurer's or health maintenance organization's gross premium receipts.

(c) Subsection (b) does not:

(1) limit the applicability of other taxes, fees, and assessments imposed by this code; or

(2) prohibit the imposition and collection of state, county, and municipal taxes on the property of insurers or health maintenance organizations or state, county, and municipal taxes imposed by other laws of this state, unless a specific exemption for insurers or health maintenance organizations is provided in those laws. (V.T.I.C. Art. 4.06.)

Sec. 203.002. TAX PAYMENT REQUIRED FOR CERTAIN CERTIFICATES; UNREPORTED GROSS PREMIUM RECEIPTS. (a) A life insurance company may not receive a certificate of authority to engage in the business of insurance in this state until all taxes imposed under this code or another insurance law of this state are paid.

(b) If the commissioner determines by examining a company or by other means that the company's gross premium receipts in a year exceed the amount reported by the company for that year, the commissioner shall report that determination to the comptroller. The comptroller shall institute a collection action as the comptroller considers appropriate to collect taxes due on unreported gross premium receipts. (V.T.I.C. Art. 4.05 (part).)

[Chapters 204-220 reserved for expansion]

SUBTITLE B. INSURANCE PREMIUM TAXES

CHAPTER 221. PROPERTY AND CASUALTY INSURANCE

PREMIUM TAX

Sec. 221.001. APPLICABILITY OF CHAPTER

Sec. 221.002. TAX IMPOSED; RATE

Sec. 221.003. TAX DUE DATES

Sec. 221.004. TAX REPORT

1 Sec. 221.005. CHANGE IN DUE DATES

2 Sec. 221.006. CREDIT FOR FEES PAID

3 Sec. 221.007. FAILURE TO PAY TAXES

4 CHAPTER 221. PROPERTY AND CASUALTY INSURANCE

5 PREMIUM TAX

6 Sec. 221.001. APPLICABILITY OF CHAPTER. (a) This chapter
7 applies to an insurer, organization, or concern that receives gross
8 premiums subject to taxation under Section 221.002, including a
9 reciprocal or interinsurance exchange that elects to be subject to
10 taxation under this chapter in accordance with Section 224.003 and
11 a Lloyd's plan.

12 (b) This chapter does not apply to:

13 (1) a fraternal benefit society, including a fraternal
14 benefit society operating under Chapter 885;

15 (2) a group hospital service corporation operating
16 under Chapter 842;

17 (3) a stipulated premium company operating under
18 Chapter 884;

19 (4) a mutual assessment association, company, or
20 corporation regulated under Chapter 887; or

21 (5) a purely cooperative or mutual fire insurance
22 company carried on by its members solely for the protection of their
23 own property and not for profit, except as provided by Section
24 221.002(b)(13). (V.T.I.C. Art. 4.10, Secs. 1 (part), 3, 4(a).)

25 Sec. 221.002. TAX IMPOSED; RATE. (a) An annual tax is
26 imposed on each insurer that receives gross premiums subject to
27 taxation under this section. The rate of the tax is 1.6 percent of

1 the insurer's taxable premium receipts for a calendar year.

2 (b) Except as provided by Subsection (c), in determining an
3 insurer's taxable premium receipts, the insurer shall include the
4 total gross amounts of premiums written by the insurer in a calendar
5 year from any kind of insurance written on property or risks located
6 in this state, including:

- 7 (1) fire insurance;
- 8 (2) ocean marine insurance;
- 9 (3) inland marine insurance;
- 10 (4) accident insurance;
- 11 (5) credit insurance;
- 12 (6) livestock insurance;
- 13 (7) fidelity insurance;
- 14 (8) guaranty insurance;
- 15 (9) surety insurance;
- 16 (10) casualty insurance;
- 17 (11) workers' compensation insurance;
- 18 (12) employers' liability insurance; and
- 19 (13) crop insurance written by a farm mutual insurance
20 company.

21 (c) The following premium receipts are not included in
22 determining an insurer's taxable premium receipts:

23 (1) premium receipts received from the business of
24 title insurance;

25 (2) premium receipts received from the business of
26 life insurance, personal accident insurance, life and accident
27 insurance, or health and accident insurance for profit, written by

1 a life insurance company, life and accident insurance company,
2 health and accident insurance company, or for mutual benefit or
3 protection in this state;

4 (3) premium receipts received from another authorized
5 insurer for reinsurance;

6 (4) returned premiums and dividends paid to
7 policyholders; and

8 (5) premiums excluded by another law of this state.

9 (d) In determining an insurer's taxable premium receipts,
10 an insurer is not entitled to a deduction for premiums paid for
11 reinsurance. (V.T.I.C. Art. 4.10, Secs. 1 (part), 2, 4(b), 5, 6(a)
12 (part), 10.)

13 Sec. 221.003. TAX DUE DATES. (a) The total tax imposed by
14 this chapter is due and payable not later than March 1 after the end
15 of the calendar year for which the tax is due.

16 (b) An insurer that had a net tax liability for the previous
17 calendar year of more than \$1,000 shall make semiannual prepayments
18 of tax on March 1 and August 1. The tax paid on each date must be
19 equal to 50 percent of the total amount of tax the insurer paid
20 under this chapter for the previous calendar year. If the insurer
21 did not pay a tax under this chapter during the previous calendar
22 year, the tax paid on each date must be equal to the tax that would
23 be owed on the aggregate of the gross premiums for the two previous
24 calendar quarters.

25 (c) The comptroller may refund any overpayment of taxes that
26 results from the semiannual prepayment system prescribed by this
27 section. (V.T.I.C. Art. 4.10, Secs. 6(a) (part), (b).)

1 Sec. 221.004. TAX REPORT. (a) An insurer liable for the
2 tax imposed by this chapter must file annually with the comptroller
3 a tax report on a form prescribed by the comptroller.

4 (b) The tax report is due on the date the tax is due under
5 Section 221.003(a). (V.T.I.C. Art. 4.10, Secs. 6(a) (part), 11.)

6 Sec. 221.005. CHANGE IN DUE DATES. (a) The comptroller by
7 rule may change the dates for reporting and paying taxes under this
8 chapter to improve operating efficiencies within the agency.

9 (b) A change by the comptroller in a reporting or payment
10 date must retain the system of semiannual prepayments prescribed by
11 Section 221.003. (V.T.I.C. Art. 4.10, Sec. 6(c).)

12 Sec. 221.006. CREDIT FOR FEES PAID. (a) Except as provided
13 by Section 803.007, an insurer is entitled to a credit on the amount
14 of tax due under this chapter for all examination and evaluation
15 fees paid to or for the use of this state during the calendar year
16 for which the tax is due.

17 (b) The credit provided by this section is in addition to
18 any other credit authorized by statute. (V.T.I.C. Art. 4.10, Sec.
19 13.)

20 Sec. 221.007. FAILURE TO PAY TAXES. An insurer that fails
21 to pay all taxes imposed by this chapter is subject to Section
22 203.002. (V.T.I.C. Art. 4.10, Sec. 15.)

23 CHAPTER 222. LIFE, HEALTH, AND ACCIDENT INSURANCE PREMIUM TAX

24 Sec. 222.001. APPLICABILITY OF CHAPTER

25 Sec. 222.002. TAX IMPOSED

26 Sec. 222.003. TAX RATES

27 Sec. 222.004. TAX DUE DATES

1 Sec. 222.005. TAX REPORT

2 Sec. 222.006. CHANGE IN DUE DATES

3 Sec. 222.007. CREDIT FOR FEES PAID

4 Sec. 222.008. FAILURE TO PAY TAXES

5 CHAPTER 222. LIFE, HEALTH, AND ACCIDENT INSURANCE PREMIUM TAX

6 Sec. 222.001. APPLICABILITY OF CHAPTER. (a) This chapter
7 applies to:

8 (1) an insurer that receives gross premiums subject to
9 taxation under Section 222.002, including:

10 (A) a life, health, or accident insurance company
11 operating under Chapter 841 or 982;

12 (B) a group hospital service corporation
13 operating under Chapter 842;

14 (C) a general casualty company operating under
15 Chapter 861;

16 (D) a statewide mutual assessment company
17 operating under Chapter 881;

18 (E) a mutual life insurance company operating
19 under Chapter 882;

20 (F) a mutual insurance company operating under
21 Chapter 883;

22 (G) a stipulated premium company operating under
23 Chapter 884;

24 (H) a Lloyd's plan operating under Chapter 941;

25 (I) a reciprocal or interinsurance exchange
26 operating under Chapter 942; and

27 (J) a Mexican casualty insurance company

operating under Chapter 984; and

(2) a health maintenance organization operating under Chapter 843 that receives gross revenues subject to taxation under Section 222.002.

(b) This chapter does not apply to:

(1) a fraternal benefit society, including a fraternal benefit society operating under Chapter 885;

(2) a local mutual aid association operating under Chapter 886; or

(3) a society that limits its membership to one occupation. (V.T.I.C. Art. 4.11, Secs. 1 (part), 2(a).)

Sec. 222.002. TAX IMPOSED. (a) An annual tax is imposed on:

(1) each insurer that receives gross premiums subject to taxation under this section; and

(2) each health maintenance organization that receives gross revenues from the sale of health maintenance certificates or contracts.

(b) Except as otherwise provided by this section, in determining an insurer's taxable gross premiums or a health maintenance organization's taxable gross revenues, the insurer or health maintenance organization shall include the total gross amounts of premiums, membership fees, assessments, dues, revenues, and other considerations received by the insurer or health maintenance organization in a calendar year from any kind of health maintenance organization certificate or contract or insurance policy or contract covering a person located in this state and

1 arising from the business of a health maintenance organization or
2 the business of life insurance, accident insurance, health
3 insurance, life and accident insurance, life and health insurance,
4 health and accident insurance, life, health, and accident
5 insurance, including variable life insurance, credit life
6 insurance, and credit accident and health insurance for profit or
7 otherwise or for mutual benefit or protection.

8 (c) The following are not included in determining an
9 insurer's taxable gross premiums or a health maintenance
10 organization's taxable gross revenues:

11 (1) returned premiums or revenues;

12 (2) dividends applied to purchase paid-up additions to
13 insurance or to shorten the endowment or premium payment period;

14 (3) premiums received from an insurer for reinsurance;

15 (4) premiums or revenues received from the treasury of
16 this state or the United States for insurance or benefits
17 contracted for by this state or the federal government:

18 (A) in accordance with or in furtherance of Title
19 2, Human Resources Code, or the Social Security Act (42 U.S.C.
20 Section 301 et seq.); or

21 (B) to provide welfare benefits to designated
22 welfare recipients;

23 (5) premiums or revenues paid on group health,
24 accident, and life policies or contracts in which the group covered
25 by the policy or contract consists of a single nonprofit trust
26 established to provide coverage primarily for employees of:

27 (A) a municipality, county, or hospital district

1 in this state; or

2 (B) a county or municipal hospital, without
3 regard to whether the employees are employees of the county or
4 municipality or of an entity operating the hospital on behalf of the
5 county or municipality; or

6 (6) premiums or revenues excluded by another law of
7 this state.

8 (d) For purposes of Subsection (c)(3), a stop-loss or excess
9 loss insurance policy issued to a health maintenance organization
10 is considered reinsurance. In determining an insurer's taxable
11 gross premiums or a health maintenance organization's taxable gross
12 revenues, an insurer or health maintenance organization is not
13 entitled to a deduction for premiums paid for reinsurance.
14 (V.T.I.C. Art. 4.11, Secs. 1, 2(c); Art. 20A.33, Sec. (a) (part);
15 New.)

16 Sec. 222.003. TAX RATES. (a) Except as provided by
17 Subsection (b), the rate of the tax imposed by this chapter on an
18 insurer is 1.75 percent of the insurer's taxable gross premiums
19 received during a calendar year.

20 (b) The rate of the tax imposed by this chapter on an insurer
21 that receives taxable gross premiums from the business of life
22 insurance is:

23 (1) 0.875 percent of the first \$450,000 of taxable
24 gross premiums received during a calendar year from the business of
25 life insurance; and

26 (2) 1.75 percent of the remaining taxable gross
27 premiums received during that calendar year from the business of

1 life insurance.

2 (c) The rate of the tax imposed by this chapter on a health
3 maintenance organization is:

4 (1) 0.875 percent of the first \$450,000 of taxable
5 gross revenues received during a calendar year for the issuance of
6 health maintenance certificates or contracts; and

7 (2) 1.75 percent of the remaining taxable gross
8 revenues received during that calendar year for the issuance of
9 health maintenance certificates or contracts. (V.T.I.C. Art. 4.11,
10 Secs. 2(f), 5F, 5G, 5H; Art. 20A.33, Sec. (a) (part).)

11 Sec. 222.004. TAX DUE DATES. (a) The total tax imposed by
12 this chapter is due and payable not later than:

13 (1) March 1 after the end of the calendar year for
14 which the tax is due;

15 (2) the date the annual statement for the insurer or
16 health maintenance organization is required to be filed with the
17 commissioner after the end of the calendar year for which the tax is
18 due; or

19 (3) another date prescribed by the comptroller.

20 (b) An insurer or health maintenance organization that had a
21 net tax liability for the previous calendar year of more than \$1,000
22 shall make semiannual prepayments of tax on March 1 and August 1.
23 The tax paid on each date must be equal to 50 percent of the total
24 amount of tax the insurer or health maintenance organization paid
25 under this chapter for the previous calendar year. If the insurer
26 or health maintenance organization did not pay a tax under this
27 chapter during the previous calendar year, the tax paid on each date

1 must be equal to the tax that would be owed on the aggregate of the
2 taxable gross premiums or taxable gross revenues for the two
3 previous calendar quarters.

4 (c) The comptroller may refund any overpayment of taxes that
5 results from the semiannual prepayment system prescribed by this
6 section. (V.T.I.C. Art. 4.11, Secs. 3 (part), 13(a).)

7 Sec. 222.005. TAX REPORT. (a) An insurer or health
8 maintenance organization liable for the tax imposed by this chapter
9 must file annually with the comptroller a tax report on a form
10 prescribed by the comptroller.

11 (b) The tax report is due on the date the tax is due under
12 Section 222.004(a).

13 (c) The comptroller may require the insurer or health
14 maintenance organization to file any additional relevant
15 information that is reasonably necessary to verify the amount of
16 tax due. (V.T.I.C. Art. 4.11, Secs. 3 (part), 6.)

17 Sec. 222.006. CHANGE IN DUE DATES. (a) The comptroller by
18 rule may change the dates for reporting and paying taxes under this
19 chapter to improve operating efficiencies within the agency.

20 (b) A change by the comptroller in a reporting or payment
21 date must retain the system of semiannual prepayments prescribed by
22 Section 222.004. (V.T.I.C. Art. 4.11, Sec. 13(b).)

23 Sec. 222.007. CREDIT FOR FEES PAID. (a) Except as provided
24 by Section 803.007, an insurer or health maintenance organization
25 is entitled to a credit on the amount of tax due under this chapter
26 for all examination and valuation fees paid to or for the use of
27 this state during the calendar year for which the tax is due.

(b) The credit provided by this section is in addition to any other credit authorized by statute. (V.T.I.C. Art. 4.11, Sec. 8.)

Sec. 222.008. FAILURE TO PAY TAXES. An insurer or health maintenance organization that fails to pay all taxes imposed by this chapter is subject to Section 203.002. (V.T.I.C. Art. 4.11, Sec. 10.)

CHAPTER 223. TITLE INSURANCE PREMIUM TAX

Sec. 223.001. APPLICABILITY OF CERTAIN DEFINITIONS

Sec. 223.002. APPLICABILITY OF CHAPTER

Sec. 223.003. TAX IMPOSED

Sec. 223.004. LIMITATION ON CERTAIN ADDITIONAL TAXES

Sec. 223.005. PREMIUMS PAID TO TITLE INSURANCE AGENT

Sec. 223.006. TAX DUE DATES

Sec. 223.007. TAX REPORTS

Sec. 223.008. RULES

Sec. 223.009. CREDIT FOR FEES PAID

Sec. 223.010. FAILURE TO PAY TAXES

Sec. 223.011. DISPOSITION OF REVENUE

CHAPTER 223. TITLE INSURANCE PREMIUM TAX

Sec. 223.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this chapter, a term defined by Chapter 2501 has the meaning assigned by that chapter. (New.)

Sec. 223.002. APPLICABILITY OF CHAPTER. This chapter applies to a title insurance company that receives premiums subject to taxation under Section 223.003. (V.T.I.C. Art. 9.59, Sec. 1 (part).)

1 Sec. 223.003. TAX IMPOSED. (a) An annual tax is imposed on
2 each title insurance company that receives premiums from the
3 business of title insurance. The rate of the tax is 1.35 percent of
4 the title insurance company's taxable premiums for a calendar year,
5 including any premiums retained by a title insurance agent as
6 provided by Section 223.005. For purposes of this chapter, a person
7 engages in the business of title insurance if the person engages in
8 an activity described by Section 2501.005.

9 (b) Except as provided by Subsection (c), in determining a
10 title insurance company's taxable premiums, the company shall
11 include the total amounts of premiums received in a calendar year
12 from title insurance written on property located in this state.

13 (c) The following premiums are not included in determining a
14 title insurance company's taxable premiums:

15 (1) premiums received from other title insurance
16 companies for reinsurance; and

17 (2) returned premiums and dividends paid to
18 policyholders.

19 (d) In determining a title insurance company's taxable
20 premiums, a title insurance company is not entitled to a deduction
21 for premiums paid for reinsurance. (V.T.I.C. Art. 9.59, Secs. 1
22 (part), 2, 3(a) (part), 4; New.)

23 Sec. 223.004. LIMITATION ON CERTAIN ADDITIONAL TAXES. (a)
24 Except as otherwise provided by this code or the Labor Code, a
25 title insurance company or title insurance agent subject to the tax
26 imposed by this chapter may not be required to pay any additional
27 tax imposed by this state or a county or municipality in proportion

1 to the company's or agent's gross premium receipts.

2 (b) This section does not:

3 (1) limit the applicability of other taxes, fees, and
4 assessments imposed by this code; or

5 (2) prohibit the imposition and collection of state,
6 county, and municipal taxes on the property of title insurance
7 companies or title insurance agents or state, county, and municipal
8 taxes imposed by other laws of this state, unless a specific
9 exemption for title insurance companies or title insurance agents
10 is provided in those laws. (V.T.I.C. Art. 9.59, Sec. 8(a).)

11 Sec. 223.005. PREMIUMS PAID TO TITLE INSURANCE AGENT. (a)
12 Premiums received from the business of title insurance are subject
13 to the tax under this chapter regardless of whether paid to a title
14 insurance company or retained by a title insurance agent, with the
15 tax being in lieu of the tax on the premiums retained by a title
16 insurance agent.

17 (b) The state facilitates the collection of the premium tax
18 on the premiums retained by a title insurance agent by establishing
19 the division of the premiums between the title insurance company
20 and title insurance agent so that the company receives the premium
21 tax due on the agent's portion of the premiums and remits it to the
22 state. (V.T.I.C. Art. 9.59, Sec. 8(b).)

23 Sec. 223.006. TAX DUE DATES. (a) The total tax imposed by
24 this chapter is due and payable not later than:

25 (1) March 1 after the end of the calendar year for
26 which the tax is due; or

27 (2) another date prescribed by the comptroller.

1 (b) A title insurance company that had a net tax liability
2 for the previous calendar year of more than \$1,000 shall make
3 semiannual prepayments of tax on March 1 and August 1. The tax paid
4 on each date must be equal to 50 percent of the total amount of tax
5 the company paid under this chapter for the previous calendar year.
6 If the company did not pay a tax under this chapter during the
7 previous calendar year, the tax paid on each date must be equal to
8 the tax that would be owed on the aggregate of the gross premiums
9 for the two previous calendar quarters.

10 (c) The comptroller may refund any overpayment of taxes that
11 results from the semiannual prepayment system prescribed by this
12 section. (V.T.I.C. Art. 9.59, Secs. 3(a) (part), (b).)

13 Sec. 223.007. TAX REPORTS. (a) A title insurance company
14 liable for the tax imposed by this chapter must file annually with
15 the comptroller a tax report on a form prescribed by the
16 comptroller.

17 (b) The tax report is due on the date the tax is due under
18 Section 223.006(a). (V.T.I.C. Art. 9.59, Secs. 3(a) (part), 5.)

19 Sec. 223.008. RULES. (a) The commissioner or the
20 comptroller, as appropriate, may adopt fair and reasonable rules,
21 minimum standards, and limitations as appropriate to augment and
22 implement this chapter.

23 (b) This section does not affect the comptroller's general
24 authority to adopt rules to promote the efficient administration,
25 collection, enforcement, and reporting of taxes under this code or
26 another insurance law of this state. (V.T.I.C. Art. 9.59, Sec.
27 3(c).)

1 Sec. 223.009. CREDIT FOR FEES PAID. (a) Except as provided
2 by Section 803.007, a title insurance company is entitled to a
3 credit on the amount of tax due under this chapter for all
4 examination and evaluation fees paid to or for the use of the state
5 during the calendar year for which the tax is due.

6 (b) The credit provided by this section is in addition to
7 any other credit authorized by statute. (V.T.I.C. Art. 9.59, Sec.
8 7.)

9 Sec. 223.010. FAILURE TO PAY TAXES. A title insurance
10 company that fails to pay all taxes imposed by this chapter is
11 subject to Section 203.002. (V.T.I.C. Art. 9.59, Sec. 9.)

12 Sec. 223.011. DISPOSITION OF REVENUE. Chapter 227 applies
13 to the disposition of the revenue from the tax imposed by this
14 chapter. (V.T.I.C. Art. 9.59, Sec. 15.)

15 CHAPTER 224. RECIPROCAL AND INTERINSURANCE

16 EXCHANGE PREMIUM TAX

17 Sec. 224.001. APPLICABILITY OF CHAPTER

18 Sec. 224.002. TAX IMPOSED; RATE

19 Sec. 224.003. TAXATION ELECTION

20 CHAPTER 224. RECIPROCAL AND INTERINSURANCE

21 EXCHANGE PREMIUM TAX

22 Sec. 224.001. APPLICABILITY OF CHAPTER. This chapter
23 applies to a reciprocal or interinsurance exchange that has a
24 certificate of authority to engage in business in this state.
25 (V.T.I.C. Arts. 4.11B, Sec. 1; 4.11C, Sec. 1.)

26 Sec. 224.002. TAX IMPOSED; RATE. (a) An annual tax is
27 imposed on each reciprocal or interinsurance exchange that:

1 (1) does not file an election to be subject to the tax
2 imposed by Chapter 221 in accordance with Section 224.003; or

3 (2) withdraws that election.

4 (b) The rate of the tax is 1.7 percent of the reciprocal or
5 interinsurance exchange's gross premium receipts.

6 (c) A reciprocal or interinsurance exchange that is subject
7 to the tax imposed by this chapter is not subject to the tax imposed
8 by Chapter 221.

9 (d) Except as provided by Subsection (b), Chapter 221
10 applies to the imposition, computation, and administration of the
11 tax imposed by this chapter in the same manner that Chapter 221
12 applies to the tax imposed by that chapter. (V.T.I.C. Arts. 4.11B,
13 Sec. 2; 4.11C, Secs. 2 (part), 5 (part).)

14 Sec. 224.003. TAXATION ELECTION. (a) A reciprocal or
15 interinsurance exchange may elect to be subject to the tax imposed
16 by Chapter 221.

17 (b) A reciprocal or interinsurance exchange that elects to
18 be subject to the tax imposed by Chapter 221 must file with the
19 comptroller on a form prescribed by the comptroller a written
20 statement that the exchange has elected to be subject to that tax.
21 The exchange must file the form not later than the 31st day before
22 the date on which the tax year for which the election is to be
23 effective begins.

24 (c) A reciprocal or interinsurance exchange that elects to
25 be subject to the tax imposed by Chapter 221 continues to be subject
26 to that tax for each tax year until the exchange withdraws the
27 election under Subsection (d).

(d) A reciprocal or interinsurance exchange may withdraw an election made under Subsection (b) by filing with the comptroller written notice of the withdrawal. The exchange must file the notice not later than the 31st day before the date on which the tax year for which the withdrawal is to be effective begins.

(e) A reciprocal or interinsurance exchange that elects to be subject to the tax imposed by Chapter 221 is not subject to the tax imposed by Section 224.002. (V.T.I.C. Art. 4.11C, Secs. 2 (part), 3, 5 (part).)

CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

Sec. 225.001. DEFINITION

Sec. 225.002. APPLICABILITY OF CHAPTER

Sec. 225.003. APPLICABILITY OF GENERAL PROVISIONS

OF OTHER LAW

Sec. 225.004. TAX IMPOSED; RATE

Sec. 225.005. TAX EXCLUSIVE

Sec. 225.006. COLLECTION OF TAX BY AGENT

Sec. 225.007. COLLECTED TAXES HELD IN TRUST

Sec. 225.008. TAX PAYMENT, REPORT, AND DUE DATE

Sec. 225.009. PREPAYMENT OF TAX

Sec. 225.010. TAX ABSORPTION AND REBATES PROHIBITED

Sec. 225.011. CANCELED OR REWRITTEN INSURANCE CONTRACT

Sec. 225.012. STATE AS PREFERRED CREDITOR

Sec. 225.013. FAILURE TO PAY TAXES; CRIMINAL PENALTY

CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

Sec. 225.001. DEFINITION. In this chapter, "premium" includes:

1 (1) a premium;
2 (2) a membership fee;
3 (3) an assessment;
4 (4) dues; and
5 (5) any other consideration for surplus lines
6 insurance. (V.T.I.C. Art. 1.14-2, Sec. 12(a) (part).)

7 Sec. 225.002. APPLICABILITY OF CHAPTER. This chapter
8 applies to a surplus lines agent who collects gross premiums for
9 surplus lines insurance. (V.T.I.C. Art. 1.14-2, Sec. 12(a)
10 (part).)

11 Sec. 225.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
12 LAW. The provisions of Chapter 981, including provisions relating
13 to the applicability and enforcement of that chapter, rulemaking
14 authority under that chapter, and definitions of terms applicable
15 in that chapter, apply to this chapter. (V.T.I.C. Art. 1.14-2, Sec.
16 12(e).)

17 Sec. 225.004. TAX IMPOSED; RATE. (a) A tax is imposed on
18 gross premiums for surplus lines insurance. The rate of the tax is
19 4.85 percent of the gross premiums.

20 (b) Taxable gross premiums under this section are based on
21 gross premiums written or received for surplus lines insurance
22 placed through an eligible surplus lines insurer during a calendar
23 year.

24 (c) If a surplus lines insurance policy covers risks or
25 exposures only partially located in this state, the tax is computed
26 on the portion of the premium that is properly allocated to a risk
27 or exposure located in this state.

1 (d) In determining the amount of taxable premiums under
2 Subsection (c), a premium, other than a premium properly allocated
3 or apportioned and reported as a premium that may be subject to
4 taxation by another state, is considered to be written on property
5 or risks located or resident in this state if the premium:

- 6 (1) is written, procured, or received in this state;
7 or
8 (2) is for a policy negotiated in this state.

9 (e) The following premiums are not taxable in this state:

10 (1) premiums properly allocated to another state that
11 are specifically exempt from taxation in that state; and

12 (2) premiums on risks or exposures that are properly
13 allocated to federal or international waters or are under the
14 jurisdiction of a foreign government. (V.T.I.C. Art. 1.14-2, Sec.
15 12(a) (part).)

16 Sec. 225.005. TAX EXCLUSIVE. The tax imposed by this
17 chapter is in lieu of all other insurance taxes. (V.T.I.C. Art.
18 1.14-2, Sec. 12(a) (part).)

19 Sec. 225.006. COLLECTION OF TAX BY AGENT. The surplus lines
20 agent shall collect from the insured the tax imposed by this chapter
21 at the time of delivery of the cover note, certificate of insurance,
22 policy, or other initial confirmation of insurance and the full
23 amount of the gross premium charged by the eligible surplus lines
24 insurer for the insurance. (V.T.I.C. Art. 1.14-2, Sec. 12(a)
25 (part).)

26 Sec. 225.007. COLLECTED TAXES HELD IN TRUST. A surplus
27 lines agent holds taxes collected under this chapter in trust.

1 (V.T.I.C. Art. 1.14-2, Sec. 12(b) (part).)

2 Sec. 225.008. TAX PAYMENT, REPORT, AND DUE DATE. (a) The
3 tax imposed by this chapter is due and payable on or before March 1.
4 A surplus lines agent shall file a tax report with the tax payment.

5 (b) A surplus lines agent shall pay the tax imposed by this
6 chapter and file the report using forms prescribed by the
7 comptroller. (V.T.I.C. Art. 1.14-2, Sec. 12(a) (part).)

8 Sec. 225.009. PREPAYMENT OF TAX. (a) A surplus lines agent
9 shall prepay the tax imposed by this chapter when the amount of the
10 accrued taxes due is equal to at least \$70,000.

11 (b) A surplus lines agent shall prepay the taxes using a
12 form prescribed by the comptroller. The prepayment is due on or
13 before the 15th day of the month following the month in which the
14 amount of taxes described by this section accrues. (V.T.I.C. Art.
15 1.14-2, Sec. 12(a) (part).)

16 Sec. 225.010. TAX ABSORPTION AND REBATES PROHIBITED. (a) A
17 surplus lines agent may not absorb the tax imposed by this chapter.

18 (b) A surplus lines agent may not rebate all or part of the
19 tax or the agent's commission as an inducement for insurance or for
20 any other reason. (V.T.I.C. Art. 1.14-2, Sec. 12(a) (part).)

21 Sec. 225.011. CANCELED OR REWRITTEN INSURANCE CONTRACT. If
22 a surplus lines insurance contract is canceled and rewritten, the
23 additional premium for purposes of the tax imposed by this chapter
24 is the premium amount that exceeds the unearned premium of the
25 canceled contract. (V.T.I.C. Art. 1.14-2, Sec. 12(a) (part).)

26 Sec. 225.012. STATE AS PREFERRED CREDITOR. If the property
27 of a surplus lines agent is seized as the result of an intermediate

1 or final decision of a court in this state, or if the business of a
2 surplus lines agent is suspended by the action of a creditor or
3 turned over to an assignee, receiver, or trustee, the tax imposed by
4 this chapter and penalties due the state from the agent are
5 preferred claims and the state is a preferred creditor and must be
6 paid in full. (V.T.I.C. Art. 1.14-2, Sec. 12(c).)

7 Sec. 225.013. FAILURE TO PAY TAXES; CRIMINAL PENALTY. (a)
8 A surplus lines agent who does not pay the tax imposed by this
9 chapter on or before the due date required by this chapter or who
10 fraudulently withholds, appropriates, or otherwise uses any
11 portion of the tax commits the offense of theft, regardless of
12 whether the surplus lines agent has or claims an interest in the
13 tax.

14 (b) An offense under this section is punishable as provided
15 by law. (V.T.I.C. Art. 1.14-2, Sec. 12(b) (part).)

16 CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED

17 INSURANCE PREMIUM TAX

18 SUBCHAPTER A. UNAUTHORIZED INSURANCE PREMIUM TAX

19 Sec. 226.001. DEFINITION

20 Sec. 226.002. APPLICABILITY OF SUBCHAPTER

21 Sec. 226.003. TAX IMPOSED; RATE

22 Sec. 226.004. TAX EXCLUSIVE

23 Sec. 226.005. TAX PAYMENT; DUE DATE

24 [Sections 226.006-226.050 reserved for expansion]

25 SUBCHAPTER B. INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

26 Sec. 226.051. DEFINITION

27 Sec. 226.052. APPLICABILITY OF SUBCHAPTER

1 Sec. 226.053. TAX IMPOSED; RATE

2 Sec. 226.054. TAX PAYMENT BY CERTAIN INSUREDS

3 Sec. 226.055. TAX PAYMENT BY CERTAIN CORPORATIONS

4 Sec. 226.056. EFFECT ON OTHER LAW

5 CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED

6 INSURANCE PREMIUM TAX

7 SUBCHAPTER A. UNAUTHORIZED INSURANCE PREMIUM TAX

8 Sec. 226.001. DEFINITION. In this subchapter, "premium"
9 includes any consideration for insurance, including:

10 (1) a premium;

11 (2) a membership fee;

12 (3) an assessment; or

13 (4) dues. (Ins. Code, Sec. 101.251(a).)

14 Sec. 226.002. APPLICABILITY OF SUBCHAPTER. This subchapter
15 applies to an unauthorized insurer who charges gross premiums for
16 insurance on a subject resident, located, or to be performed in this
17 state. (Ins. Code, Sec. 101.251(b) (part).)

18 Sec. 226.003. TAX IMPOSED; RATE. (a) A tax is imposed on
19 each unauthorized insurer that charges gross premiums subject to
20 taxation under this section. The rate of the tax is 4.85 percent of
21 the gross premiums charged by the unauthorized insurer.

22 (b) Except as otherwise provided by this section, in
23 determining an unauthorized insurer's taxable gross premiums, the
24 insurer shall include any premium for insurance on a subject
25 resident, located, or to be performed in this state.

26 (c) If a policy covers risks or exposures only partially
27 located in this state, the tax is computed on the portion of the

1 premium that is properly allocated to a risk or exposure located in
2 this state.

3 (d) In determining the amount of taxable premiums under
4 Subsection (c), a premium, other than a premium properly allocated
5 or apportioned and reported as a taxable premium of another state,
6 is considered to be written on property or risks located or resident
7 in this state if the premium:

8 (1) is written, procured, or received in this state;
9 or

10 (2) is for a policy negotiated in this state.

11 (e) Insurance on a subject resident, located, or to be
12 performed in this state is considered to be insurance procured,
13 continued, or renewed in this state regardless of the location from
14 which:

- 15 (1) the application is made;
16 (2) the negotiations are conducted; or
17 (3) the premiums are remitted.

18 (f) Premiums on risks or exposures that are properly
19 allocated to federal waters or international waters or are under
20 the jurisdiction of a foreign government are not taxable by this
21 state.

22 (g) The following premiums are not subject to the tax
23 imposed by this subchapter:

- 24 (1) premiums on insurance procured by a licensed
25 surplus lines agent from an eligible surplus lines insurer as
26 defined by Chapter 981 on which premium tax is paid in accordance
27 with Chapter 225; and

1 (2) premiums on an independently procured contract of
2 insurance on which premium tax is paid in accordance with
3 Subchapter B. (Ins. Code, Secs. 101.251(b) (part), (c), (d), (e),
4 (f), (j).)

5 Sec. 226.004. TAX EXCLUSIVE. The tax imposed by this
6 subchapter is in lieu of all other insurance taxes. (Ins. Code,
7 Sec. 101.251(h).)

8 Sec. 226.005. TAX PAYMENT; DUE DATE. (a) The tax imposed
9 by this subchapter is due and payable not later than:

10 (1) March 1 after the end of the calendar year in which
11 the insurance was effectuated, continued, or renewed; or

12 (2) another date prescribed by the comptroller.

13 (b) An unauthorized insurer shall pay the tax imposed by
14 this subchapter using a form prescribed by the comptroller.

15 (c) If an unauthorized insurer defaults in payment of the
16 tax imposed by this subchapter, the insured is responsible for
17 paying the tax. (Ins. Code, Secs. 101.251(b) (part), (g), (i).)

18 [Sections 226.006-226.050 reserved for expansion]

19 SUBCHAPTER B. INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

20 Sec. 226.051. DEFINITION. In this subchapter, "premium"
21 includes any consideration for insurance, including:

22 (1) a premium;

23 (2) a membership fee; or

24 (3) dues. (Ins. Code, Sec. 101.252(a).)

25 Sec. 226.052. APPLICABILITY OF SUBCHAPTER. This subchapter
26 applies to an insured who procures an insurance contract in
27 accordance with Section 101.053(b)(4). (Ins. Code, Sec. 101.252(b)

(part).)

Sec. 226.053. TAX IMPOSED; RATE. (a) A tax is imposed on each insured at the rate of 4.85 percent of the premium paid for the insurance contract procured in accordance with Section 101.053(b)(4).

(b) If an insurance contract covers risks or exposures only partially located in this state, the tax is computed on the portion of the premium that is properly allocated to a risk or exposure located in this state.

(c) Premiums for individual life or individual disability insurance are not included in determining an insured's taxable premiums. (Ins. Code, Secs. 101.252(b) (part), (c), (g).)

Sec. 226.054. TAX PAYMENT BY CERTAIN INSURED. (a) Except as provided by Section 226.055, the tax imposed by this subchapter is due and payable not later than:

(1) May 15 after the end of the calendar year in which the insurance was procured, continued, or renewed; or

(2) another date prescribed by the comptroller.

(b) An insured who fails to withhold from the premium the amount of tax imposed by this subchapter is liable for the amount of the tax and shall pay the tax due.

(c) The insured shall file a tax report and pay the tax.

(d) The insured may designate another person to file the report and pay the tax. (Ins. Code, Secs. 101.252(b) (part), (d), (e).)

Sec. 226.055. TAX PAYMENT BY CERTAIN CORPORATIONS. The amount of tax due and payable under this subchapter by a corporation

that files a franchise tax report shall be reported directly to the comptroller and is due:

- (1) at the time the franchise tax report is due; or
 - (2) on another date prescribed by the comptroller.
- (Ins. Code, Sec. 101.253.)

Sec. 226.056. EFFECT ON OTHER LAW. Sections 226.051-226.054 do not abrogate or modify any other provision of this chapter or Chapter 101. (Ins. Code, Sec. 101.252(f).)

CHAPTER 227. DISPOSITION OF PROCEEDS
OF CERTAIN PREMIUM TAXES

Sec. 227.001. DISPOSITION OF TAX PROCEEDS

CHAPTER 227. DISPOSITION OF PROCEEDS
OF CERTAIN PREMIUM TAXES

Sec. 227.001. DISPOSITION OF TAX PROCEEDS. (a) The proceeds of the taxes imposed under Chapter 221, 222, 224, or 226 shall be deposited to the credit of the general revenue fund.

(b) An amount equal to one-fourth of the proceeds deposited under Subsection (a) shall be transferred to the credit of the foundation school fund. (V.T.I.C. Art. 4.12.)

[Chapters 228-250 reserved for expansion]

SUBTITLE C. INSURANCE MAINTENANCE TAXES

CHAPTER 251. GENERAL PROVISIONS

Sec. 251.001. DETERMINING RATE OF ASSESSMENT

Sec. 251.002. DUTY TO ADVISE COMPTROLLER OF RATE

Sec. 251.003. EFFECT OF LATE ADVISEMENT OF RATE

Sec. 251.004. DEPOSIT OF MAINTENANCE TAXES

CHAPTER 251. GENERAL PROVISIONS

1 Sec. 251.001. DETERMINING RATE OF ASSESSMENT. (a) The
2 commissioner shall annually determine the rate of assessment of
3 each maintenance tax imposed under this subtitle.

4 (b) In determining the rate of assessment, the commissioner
5 shall consider the requirement to reimburse the appropriate portion
6 of the general revenue fund under Section 201.052. (V.T.I.C. Art.
7 1.14-3, Secs. 8(a) (part), (b) (part); Art. 4.17, Secs. (a) (part),
8 (c) (part); Art. 5.12, Secs. (a) (part), (c) (part); Art. 5.24,
9 Secs. (a) (part), (c) (part); Art. 5.49, Secs. (a) (part), (c)
10 (part); Art. 5.68, Secs. (a) (part), (d) (part); Art. 5.91, Secs.
11 (a) (part), (c) (part); Art. 20A.33, Secs. (d) (part), (f) (part);
12 Art. 21.07-6, Secs. 21(a) (part), (c) (part); Art. 23.08A, Secs.
13 (a) (part), (c) (part).)

14 Sec. 251.002. DUTY TO ADVISE COMPTROLLER OF RATE. The
15 commissioner shall advise the comptroller of the applicable rate of
16 assessment of a maintenance tax not later than the 45th day before
17 the due date of the tax report for the period for which that tax is
18 due. (V.T.I.C. Art. 1.14-3, Sec. 8(d) (part); Art. 4.17, Sec. (g)
19 (part); Art. 5.12, Sec. (f) (part); Art. 5.24, Sec. (f) (part); Art.
20 5.49, Sec. (f) (part); Art. 5.68, Sec. (g) (part); Art. 5.91, Sec.
21 (f) (part); Art. 20A.33, Sec. (i) (part); Art. 21.07-6, Sec. 21(e)
22 (part); Art. 23.08A, Sec. (g) (part).)

23 Sec. 251.003. EFFECT OF LATE ADVISEMENT OF RATE. (a)
24 Except as provided by Subsection (b), if the commissioner does not
25 advise the comptroller of the applicable rate of assessment of a
26 maintenance tax by the date required by Section 251.002, the rate of
27 assessment is the rate applied in the previous tax period.

(b) If the commissioner advises the comptroller of the applicable rate of assessment of a maintenance tax after the tax has been assessed, the comptroller shall:

(1) advise each taxpayer in writing of the amount of any additional taxes due; or

(2) refund any excess taxes paid. (V.T.I.C. Art. 1.14-3, Sec. 8(d) (part); Art. 4.17, Sec. (g) (part); Art. 5.12, Sec. (f) (part); Art. 5.24, Sec. (f) (part); Art. 5.49, Sec. (f) (part); Art. 5.68, Sec. (g) (part); Art. 5.91, Sec. (f) (part); Art. 20A.33, Sec. (i) (part); Art. 21.07-6, Sec. 21(e) (part); Art. 23.08A, Sec. (g) (part).)

Sec. 251.004. DEPOSIT OF MAINTENANCE TAXES. Maintenance taxes collected under this subtitle shall be deposited in the general revenue fund and reallocated to the Texas Department of Insurance operating account. (V.T.I.C. Art. 1.14-3, Sec. 8(c) (part); Art. 4.17, Sec. (d) (part); Art. 5.12, Sec. (d) (part); Art. 5.24, Sec. (d) (part); Art. 5.49, Sec. (d) (part); Art. 5.68, Sec. (e) (part); Art. 5.91, Sec. (d) (part); Art. 20A.33, Sec. (g) (part); Art. 21.07-6, Sec. 21(d) (part); Art. 23.08A, Sec. (d) (part).)

CHAPTER 252. FIRE AND ALLIED LINES INSURANCE

Sec. 252.001. MAINTENANCE TAX IMPOSED

Sec. 252.002. MAXIMUM RATE; ANNUAL ADJUSTMENT

Sec. 252.003. PREMIUMS SUBJECT TO TAXATION

Sec. 252.004. MAINTENANCE TAX DUE DATES

CHAPTER 252. FIRE AND ALLIED LINES INSURANCE

Sec. 252.001. MAINTENANCE TAX IMPOSED. A maintenance tax

1 is imposed on each authorized insurer with gross premiums subject
2 to taxation under Section 252.003. The tax required by this chapter
3 is in addition to other taxes imposed that are not in conflict with
4 this chapter. (V.T.I.C. Art. 5.49, Secs. (a) (part), (b).)

5 Sec. 252.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
6 rate of assessment set by the commissioner may not exceed 1.25
7 percent of the gross premiums subject to taxation under Section
8 252.003.

9 (b) The commissioner shall annually adjust the rate of
10 assessment of the maintenance tax so that the tax imposed that year,
11 together with any unexpended funds produced by the tax, produces
12 the amount the commissioner determines is necessary to pay the
13 expenses during the succeeding year of regulating all classes of
14 insurance specified under Subchapter C, Chapter 5. (V.T.I.C. Art.
15 5.49, Secs. (a) (part), (c) (part).)

16 Sec. 252.003. PREMIUMS SUBJECT TO TAXATION. An insurer
17 shall pay maintenance taxes under this chapter on the correctly
18 reported gross premiums collected from writing insurance in this
19 state against loss or damage by:

- 20 (1) bombardment;
- 21 (2) civil war or commotion;
- 22 (3) cyclone;
- 23 (4) earthquake;
- 24 (5) excess or deficiency of moisture;
- 25 (6) explosion as defined by Article 5.52;
- 26 (7) fire;
- 27 (8) flood;

- 1 (9) frost and freeze;
- 2 (10) hail;
- 3 (11) insurrection;
- 4 (12) invasion;
- 5 (13) lightning;
- 6 (14) military or usurped power;
- 7 (15) an order of a civil authority made to prevent the
- 8 spread of a conflagration, epidemic, or catastrophe;
- 9 (16) rain;
- 10 (17) riot;
- 11 (18) the rising of the waters of the ocean or its
- 12 tributaries;
- 13 (19) smoke or smudge;
- 14 (20) strike or lockout;
- 15 (21) tornado;
- 16 (22) vandalism or malicious mischief;
- 17 (23) volcanic eruption;
- 18 (24) water or other fluid or substance resulting from
- 19 the breakage or leakage of sprinklers, pumps, or other apparatus
- 20 erected for extinguishing fires, water pipes, or other conduits or
- 21 containers;
- 22 (25) weather or climatic conditions; or
- 23 (26) windstorm. (V.T.I.C. Art. 5.49, Sec. (a)
- 24 (part).)

25 Sec. 252.004. MAINTENANCE TAX DUE DATES. (a) The insurer
26 shall pay the maintenance tax annually or semiannually, as
27 determined by the comptroller.

1 (b) The comptroller may require semiannual or other
2 periodic payment only from an insurer whose maintenance tax
3 liability under this chapter for the previous tax year was at least
4 \$2,000. (V.T.I.C. Art. 5.49, Secs. (a) (part), (e).)

5 CHAPTER 253. CASUALTY INSURANCE AND FIDELITY, GUARANTY,
6 AND SURETY BOND INSURANCE

7 Sec. 253.001. MAINTENANCE TAX IMPOSED

8 Sec. 253.002. MAXIMUM RATE; ANNUAL ADJUSTMENT

9 Sec. 253.003. PREMIUMS SUBJECT TO TAXATION

10 Sec. 253.004. MAINTENANCE TAX DUE DATES

11 CHAPTER 253. CASUALTY INSURANCE AND FIDELITY, GUARANTY,
12 AND SURETY BOND INSURANCE

13 Sec. 253.001. MAINTENANCE TAX IMPOSED. A maintenance tax
14 is imposed on each authorized insurer with gross premiums subject
15 to taxation under Section 253.003. The tax required by this chapter
16 is in addition to other taxes imposed that are not in conflict with
17 this chapter. (V.T.I.C. Art. 5.24, Secs. (a) (part), (b).)

18 Sec. 253.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
19 rate of assessment set by the commissioner may not exceed 0.4
20 percent of the gross premiums subject to taxation under Section
21 253.003.

22 (b) The commissioner shall annually adjust the rate of
23 assessment of the maintenance tax so that the tax imposed that year,
24 together with any unexpended funds produced by the tax, produces
25 the amount the commissioner determines is necessary to pay the
26 expenses during the succeeding year of regulating all classes of
27 insurance specified under Subchapter B, Chapter 5. (V.T.I.C. Art.

5.24, Secs. (a) (part), (c) (part).)

Sec. 253.003. PREMIUMS SUBJECT TO TAXATION. An insurer shall pay maintenance taxes under this chapter on the correctly reported gross premiums from writing a class of insurance specified under Subchapter B, Chapter 5. (V.T.I.C. Art. 5.24, Sec. (a) (part).)

Sec. 253.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually or semiannually, as determined by the comptroller.

(b) The comptroller may require semiannual payment only from an insurer whose maintenance tax liability under this chapter for the previous tax year was at least \$2,000. (V.T.I.C. Art. 5.24, Secs. (a) (part), (e).)

CHAPTER 254. MOTOR VEHICLE INSURANCE

Sec. 254.001. MAINTENANCE TAX IMPOSED

Sec. 254.002. MAXIMUM RATE; ANNUAL ADJUSTMENT

Sec. 254.003. PREMIUMS SUBJECT TO TAXATION

Sec. 254.004. MAINTENANCE TAX DUE DATES

CHAPTER 254. MOTOR VEHICLE INSURANCE

Sec. 254.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 254.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 5.12, Secs. (a) (part), (b).)

Sec. 254.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 0.2 percent of the gross premiums subject to taxation under Section

1 254.003.

2 (b) The commissioner shall annually adjust the rate of
3 assessment of the maintenance tax so that the tax imposed that year,
4 together with any unexpended funds produced by the tax, produces
5 the amount the commissioner determines is necessary to pay the
6 expenses during the succeeding year of regulating motor vehicle
7 insurance. (V.T.I.C. Art. 5.12, Secs. (a) (part), (c) (part).)

8 Sec. 254.003. PREMIUMS SUBJECT TO TAXATION. An insurer
9 shall pay maintenance taxes under this chapter on the correctly
10 reported gross premiums from writing motor vehicle insurance in
11 this state. (V.T.I.C. Art. 5.12, Sec. (a) (part).)

12 Sec. 254.004. MAINTENANCE TAX DUE DATES. (a) The insurer
13 shall pay the maintenance tax annually or semiannually, as
14 determined by the comptroller.

15 (b) The comptroller may require semiannual or other
16 periodic payment only from an insurer whose maintenance tax
17 liability under this chapter for the previous tax year was at least
18 \$2,000. (V.T.I.C. Art. 5.12, Secs. (a) (part), (e).)

19 CHAPTER 255. WORKERS' COMPENSATION INSURANCE

20 Sec. 255.001. MAINTENANCE TAX IMPOSED

21 Sec. 255.002. MAXIMUM RATE; ANNUAL ADJUSTMENT

22 Sec. 255.003. PREMIUMS SUBJECT TO TAXATION

23 Sec. 255.004. MAINTENANCE TAX DUE DATES

24 CHAPTER 255. WORKERS' COMPENSATION INSURANCE

25 Sec. 255.001. MAINTENANCE TAX IMPOSED. (a) A maintenance
26 tax is imposed on each authorized insurer with gross premiums
27 subject to taxation under Section 255.003, including a:

- (1) stock insurance company;
- (2) mutual insurance company;
- (3) reciprocal or interinsurance exchange; and
- (4) Lloyd's plan.

(b) The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 5.68, Secs. (a) (part), (c).)

Sec. 255.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 0.6 percent of the gross premiums subject to taxation under Section 255.003.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating workers' compensation insurance. (V.T.I.C. Art. 5.68, Secs. (a) (part), (d) (part).)

Sec. 255.003. PREMIUMS SUBJECT TO TAXATION. (a) An insurer shall pay maintenance taxes under this chapter on the correctly reported gross workers' compensation insurance premiums from writing workers' compensation insurance in this state, including the modified annual premium of a policyholder that purchases an optional deductible plan under Article 5.55C.

(b) The rate of assessment shall be applied to the modified annual premium before application of a deductible premium credit. (V.T.I.C. Art. 5.68, Secs. (a) (part), (b) (part).)

1 Sec. 255.004. MAINTENANCE TAX DUE DATES. (a) The insurer
2 shall pay the maintenance tax annually or semiannually.

3 (b) The comptroller may require semiannual payment only
4 from an insurer whose maintenance tax liability under this chapter
5 for the previous tax year was at least \$2,000. (V.T.I.C. Art. 5.68,
6 Secs. (a) (part), (f).)

7 CHAPTER 256. AIRCRAFT INSURANCE

8 Sec. 256.001. MAINTENANCE TAX IMPOSED

9 Sec. 256.002. MAXIMUM RATE; ANNUAL ADJUSTMENT

10 Sec. 256.003. PREMIUMS SUBJECT TO TAXATION

11 Sec. 256.004. MAINTENANCE TAX DUE DATES

12 CHAPTER 256. AIRCRAFT INSURANCE

13 Sec. 256.001. MAINTENANCE TAX IMPOSED. A maintenance tax
14 is imposed on each authorized insurer with gross premiums subject
15 to taxation under Section 256.003. The tax required by this chapter
16 is in addition to other taxes imposed that are not in conflict with
17 this chapter. (V.T.I.C. Art. 5.91, Secs. (a) (part), (b).)

18 Sec. 256.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
19 rate of assessment set by the commissioner may not exceed 0.4
20 percent of the gross premiums subject to taxation under Section
21 256.003.

22 (b) The commissioner shall annually adjust the rate of
23 assessment of the maintenance tax so that the tax imposed that year,
24 together with any unexpended funds produced by the tax, produces
25 the amount the commissioner determines is necessary to pay the
26 expenses during the succeeding year of regulating all classes of
27 insurance specified under Subchapter K, Chapter 5. (V.T.I.C. Art.

1 5.91, Secs. (a) (part), (c) (part).)

2 Sec. 256.003. PREMIUMS SUBJECT TO TAXATION. An insurer
3 shall pay maintenance taxes under this chapter on the correctly
4 reported gross premiums from writing a class of insurance specified
5 under Subchapter K, Chapter 5. (V.T.I.C. Art. 5.91, Sec. (a)
6 (part).)

7 Sec. 256.004. MAINTENANCE TAX DUE DATES. (a) The insurer
8 shall pay the maintenance tax annually or semiannually, as
9 determined by the comptroller.

10 (b) The comptroller may require semiannual payment only
11 from an insurer whose maintenance tax liability under this chapter
12 for the previous tax year was at least \$2,000. (V.T.I.C. Art. 5.91,
13 Secs. (a) (part), (e).)

14 CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE

15 Sec. 257.001. MAINTENANCE TAX IMPOSED

16 Sec. 257.002. MAXIMUM RATE; ANNUAL ADJUSTMENT

17 Sec. 257.003. PREMIUMS AND CONSIDERATIONS SUBJECT TO

18 TAXATION; LIMIT

19 Sec. 257.004. MAINTENANCE TAX DUE DATES

20 CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE

21 Sec. 257.001. MAINTENANCE TAX IMPOSED. A maintenance tax
22 is imposed on each authorized insurer, including a group hospital
23 service corporation, local mutual aid association, statewide
24 mutual assessment company, stipulated premium company, and stock or
25 mutual insurance company, that collects from residents of this
26 state gross premiums or gross considerations subject to taxation
27 under Section 257.003. The tax required by this chapter is in

1 addition to other taxes imposed that are not in conflict with this
2 chapter. (V.T.I.C. Art. 4.17, Secs. (a) (part), (b), (f).)

3 Sec. 257.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
4 rate of assessment set by the commissioner may not exceed 0.04
5 percent of the gross premiums and gross considerations subject to
6 taxation under Section 257.003.

7 (b) The commissioner shall annually adjust the rate of
8 assessment of the maintenance tax so that the tax imposed that year,
9 together with any unexpended funds produced by the tax, produces
10 the amount the commissioner determines is necessary to pay the
11 expenses during the succeeding year of regulating life, health, and
12 accident insurers. (V.T.I.C. Art. 4.17, Secs. (a) (part), (c)
13 (part).)

14 Sec. 257.003. PREMIUMS AND CONSIDERATIONS SUBJECT TO
15 TAXATION; LIMIT. (a) An insurer shall pay maintenance taxes under
16 this chapter on the correctly reported:

17 (1) gross premiums collected from writing life,
18 health, and accident insurance in this state, except as provided in
19 Subsection (b); and

20 (2) gross considerations collected from writing
21 annuity or endowment contracts in this state.

22 (b) The gross premiums on which an assessment is based under
23 this chapter may not include premiums received from this state or
24 the United States for insurance contracted for by this state or the
25 United States:

26 (1) in accordance with or in furtherance of Title 2,
27 Human Resources Code, or the Social Security Act (42 U.S.C. Section

301 et seq.); or

(2) to provide welfare benefits to designated welfare recipients. (V.T.I.C. Art. 4.17, Sec. (a) (part).)

Sec. 257.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually, semiannually, or on another periodic basis, as determined by the comptroller.

(b) The comptroller may require semiannual or other periodic payment only from an insurer whose maintenance tax liability under this chapter for the previous year was at least \$2,000. (V.T.I.C. Art. 4.17, Secs. (a) (part), (e).)

CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS

Sec. 258.001. APPLICABILITY OF CERTAIN DEFINITIONS

Sec. 258.002. MAINTENANCE TAX IMPOSED

Sec. 258.003. MAXIMUM RATE; ANNUAL ADJUSTMENT

Sec. 258.004. REVENUES SUBJECT TO TAXATION; LIMIT

Sec. 258.005. MAINTENANCE TAX DUE DATES

CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS

Sec. 258.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this chapter, a term defined by Section 843.002 has the meaning assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts 77th Leg., R.S., Ch. 1419.)

Sec. 258.002. MAINTENANCE TAX IMPOSED. A per capita maintenance tax is imposed on each authorized health maintenance organization with gross revenues subject to taxation under Section 258.004. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 20A.33, Secs. (d) (part), (e).)

1 Sec. 258.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
2 rate of assessment set by the commissioner may not exceed \$2 per
3 enrollee.

4 (b) The commissioner shall annually adjust the rate of
5 assessment of the per capita maintenance tax so that the tax imposed
6 that year, together with any unexpended funds produced by the tax,
7 produces the amount the commissioner determines is necessary to pay
8 the expenses during the succeeding year of regulating health
9 maintenance organizations.

10 (c) The rate of assessment may differ between basic health
11 care plans, limited health care service plans, and single health
12 care service plans and must equitably reflect any differences in
13 regulatory resources attributable to each type of plan. (V.T.I.C.
14 Art. 20A.33, Secs. (d) (part), (f) (part).)

15 Sec. 258.004. REVENUES SUBJECT TO TAXATION; LIMIT. (a) A
16 health maintenance organization shall pay per capita maintenance
17 taxes under this chapter on the correctly reported gross revenues
18 collected from issuing health maintenance certificates or
19 contracts in this state.

20 (b) The amount of maintenance tax assessed may not be
21 computed based on enrollees who as individual certificate holders
22 or their dependents are covered by a master group policy paid for by
23 revenues received from this state or the United States for
24 insurance contracted for by this state or the United States:

25 (1) in accordance with or in furtherance of Title 2,
26 Human Resources Code, or the Social Security Act (42 U.S.C. Section
27 301 et seq.); or

(2) to provide welfare benefits to designated welfare recipients. (V.T.I.C. Art. 20A.33, Sec. (d) (part).)

Sec. 258.005. MAINTENANCE TAX DUE DATES. (a) The health maintenance organization shall pay the maintenance tax annually or semiannually.

(b) The comptroller may require semiannual or other periodic payment only from a health maintenance organization whose maintenance tax liability under this chapter for the previous year was at least \$2,000. (V.T.I.C. Art. 20A.33, Secs. (d) (part), (h).)

CHAPTER 259. THIRD-PARTY ADMINISTRATORS

Sec. 259.001. DEFINITIONS

Sec. 259.002. MAINTENANCE TAX IMPOSED

Sec. 259.003. MAXIMUM RATE; ANNUAL ADJUSTMENT

Sec. 259.004. ADMINISTRATIVE AND SERVICE FEES SUBJECT TO

TAXATION

Sec. 259.005. MAINTENANCE TAX DUE DATES

CHAPTER 259. THIRD-PARTY ADMINISTRATORS

Sec. 259.001. DEFINITIONS. In this chapter:

(1) "Administrative or service fees" means all consideration, fees, assessments, payments, reimbursements, dues, and other compensation received for services as an administrator during a calendar year. The term does not include sales commissions.

(2) "Administrator" has the meaning assigned by Section 4151.001. (V.T.I.C. Art. 21.07-6, Sec. 1(2); New.)

Sec. 259.002. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized administrator with administrative or

1 service fees subject to taxation under Section 259.004. The tax
2 required by this chapter is in addition to other taxes imposed that
3 are not in conflict with this chapter. (V.T.I.C. Art. 21.07-6,
4 Secs. 21(a) (part), (b).)

5 Sec. 259.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
6 rate of assessment set by the commissioner may not exceed one
7 percent of the administrative or service fees subject to taxation
8 under Section 259.004.

9 (b) The commissioner shall annually adjust the rate of
10 assessment of the maintenance tax so that the tax imposed that year,
11 together with any unexpended funds produced by the tax, produces
12 the amount the commissioner determines is necessary to pay the
13 expenses of regulating administrators. (V.T.I.C. Art. 21.07-6,
14 Secs. 21(a) (part), (c) (part).)

15 Sec. 259.004. ADMINISTRATIVE AND SERVICE FEES SUBJECT TO
16 TAXATION. An administrator shall pay maintenance taxes under this
17 chapter on the administrator's correctly reported administrative
18 or service fees. (V.T.I.C. Art. 21.07-6, Sec. 21(a) (part).)

19 Sec. 259.005. MAINTENANCE TAX DUE DATES. The administrator
20 shall pay the maintenance tax annually, semiannually, or on another
21 periodic basis, as determined by the comptroller. (V.T.I.C. Art.
22 21.07-6, Sec. 21(a) (part).)

23 CHAPTER 260. NONPROFIT LEGAL SERVICES CORPORATIONS

24 Sec. 260.001. MAINTENANCE TAX IMPOSED

25 Sec. 260.002. MAXIMUM RATE; ANNUAL ADJUSTMENT

26 Sec. 260.003. REVENUES SUBJECT TO TAXATION

27 Sec. 260.004. MAINTENANCE TAX DUE DATES; RULES

1 Sec. 260.005. APPLICABILITY OF OTHER LAW

2 CHAPTER 260. NONPROFIT LEGAL SERVICES CORPORATIONS

3 Sec. 260.001. MAINTENANCE TAX IMPOSED. A maintenance tax
4 is imposed on each nonprofit legal services corporation subject to
5 Chapter 961 with gross revenues subject to taxation under Section
6 260.003. The tax required by this chapter is in addition to other
7 taxes imposed that are not in conflict with this chapter. (V.T.I.C.
8 Art. 23.08A, Secs. (a) (part), (b).)

9 Sec. 260.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
10 rate of assessment set by the commissioner may not exceed one
11 percent of the corporation's gross revenues subject to taxation
12 under Section 260.003.

13 (b) The commissioner shall annually adjust the rate of
14 assessment of the maintenance tax so that the tax imposed that year,
15 together with any unexpended funds produced by the tax, produces
16 the amount the commissioner determines is necessary to pay the
17 expenses during the succeeding year of regulating nonprofit legal
18 services corporations. (V.T.I.C. Art. 23.08A, Secs. (a) (part),
19 (c) (part).)

20 Sec. 260.003. REVENUES SUBJECT TO TAXATION. A corporation
21 shall pay maintenance taxes under this chapter on the correctly
22 reported gross revenues received from issuing prepaid legal
23 services contracts in this state. (V.T.I.C. Art. 23.08A, Sec. (a)
24 (part).)

25 Sec. 260.004. MAINTENANCE TAX DUE DATES; RULES. (a) The
26 corporation shall pay the maintenance tax annually or semiannually.

27 (b) The comptroller may require semiannual payments only

1 from a corporation whose maintenance tax liability under this
2 chapter for the previous tax year was at least \$2,000.

3 (c) The comptroller may adopt reasonable rules to implement
4 semiannual payments that the comptroller considers advisable.
5 (V.T.I.C. Art. 23.08A, Secs. (a) (part), (f).)

6 Sec. 260.005. APPLICABILITY OF OTHER LAW. Sections 201.001
7 and 201.002 apply to taxes collected under this chapter. (V.T.I.C.
8 Art. 23.08A, Sec. (e).)

9 CHAPTER 261. TEXAS INSURANCE EXCHANGE

10 Sec. 261.001. DEFINITION

11 Sec. 261.002. MAINTENANCE TAX IMPOSED

12 Sec. 261.003. MAXIMUM RATE; ANNUAL ADJUSTMENT

13 Sec. 261.004. PREMIUMS SUBJECT TO TAXATION

14 Sec. 261.005. MAINTENANCE TAX DUE DATES

15 CHAPTER 261. TEXAS INSURANCE EXCHANGE

16 Sec. 261.001. DEFINITION. In this chapter, "exchange"
17 means the Texas Insurance Exchange. (V.T.I.C. Art. 1.14-3, Sec.
18 1(1).)

19 Sec. 261.002. MAINTENANCE TAX IMPOSED. A maintenance tax is
20 imposed on the gross premiums paid through the exchange and subject
21 to taxation under Section 261.004. (V.T.I.C. Art. 1.14-3, Sec.
22 8(a) (part).)

23 Sec. 261.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
24 rate of assessment set by the commissioner may not exceed one
25 percent of the gross premiums subject to taxation under Section
26 261.004.

27 (b) The commissioner shall annually adjust the rate of

1 assessment of the maintenance tax so that the tax imposed that year,
2 together with any unexpended funds produced by the tax, produces
3 the amount the commissioner determines is necessary to pay the
4 expenses during the succeeding year of regulating all classes of
5 insurance specified under Article 1.14-3. (V.T.I.C. Art. 1.14-3,
6 Secs. 8(a) (part), (b) (part).)

7 Sec. 261.004. PREMIUMS SUBJECT TO TAXATION. The exchange
8 shall pay maintenance taxes under this chapter on the correctly
9 reported gross premiums paid through the exchange on all classes of
10 insurance specified under Article 1.14-3. (V.T.I.C. Art. 1.14-3,
11 Sec. 8(a) (part).)

12 Sec. 261.005. MAINTENANCE TAX DUE DATES. The exchange
13 shall pay the maintenance tax annually, semiannually, or on another
14 periodic basis, as determined by the comptroller. (V.T.I.C. Art.
15 1.14-3, Sec. 8(a) (part).)

16 [Chapters 262-270 reserved for expansion]

17 SUBTITLE D. TITLE INSURANCE MAINTENANCE FEES

18 CHAPTER 271. TITLE INSURANCE MAINTENANCE FEES

19 Sec. 271.001. APPLICABILITY OF CERTAIN DEFINITIONS

20 Sec. 271.002. MAINTENANCE FEE IMPOSED

21 Sec. 271.003. DUPLICATION OF ASSESSMENT PROHIBITED WITH

22 RESPECT TO TITLE INSURANCE AGENTS

23 Sec. 271.004. DETERMINING RATE OF ASSESSMENT

24 Sec. 271.005. MAXIMUM RATE; ANNUAL ADJUSTMENT

25 Sec. 271.006. PREMIUMS SUBJECT TO ASSESSMENT

26 Sec. 271.007. COLLECTION OF MAINTENANCE FEE

27 Sec. 271.008. DUTY TO ADVISE COMPTROLLER OF RATE

1 Sec. 271.009. EFFECT OF LATE ADVISEMENT OF RATE

2 Sec. 271.010. DEPOSIT OF MAINTENANCE FEES

3 Sec. 271.011. MAINTENANCE FEE DUE DATES

4 Sec. 271.012. RULES

5 CHAPTER 271. TITLE INSURANCE MAINTENANCE FEES

6 Sec. 271.001. APPLICABILITY OF CERTAIN DEFINITIONS. In
7 this chapter, a term defined by Chapter 2501 has the meaning
8 assigned by that chapter. (New.)

9 Sec. 271.002. MAINTENANCE FEE IMPOSED. (a) A maintenance
10 fee is imposed on each insurer with gross premiums subject to
11 assessment under Section 271.006.

12 (b) The maintenance fee is not a tax and shall be reported
13 and paid separately from premium and retaliatory taxes. (V.T.I.C.
14 Art. 9.46, Sec. (a) (part), as amended Acts 73rd Leg., R.S., Ch.
15 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd
16 Leg., R.S., Ch. 486, Sec. 6.04.)

17 Sec. 271.003. DUPLICATION OF ASSESSMENT PROHIBITED WITH
18 RESPECT TO TITLE INSURANCE AGENTS. The maintenance fee is included
19 in the division of premiums and may not be separately charged to a
20 title insurance agent. (V.T.I.C. Art. 9.46, Sec. (a) (part), as
21 amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46
22 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

23 Sec. 271.004. DETERMINING RATE OF ASSESSMENT. (a) The
24 commissioner shall annually determine the rate of assessment of the
25 maintenance fee.

26 (b) In determining the rate of assessment, the commissioner
27 shall consider the requirement to reimburse the appropriate portion

1 of the general revenue fund under Section 201.052. (V.T.I.C. Art.
2 9.46, Secs. (a) (part), (b) (part), as amended Acts 73rd Leg., R.S.,
3 Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd
4 Leg., R.S., Ch. 486, Sec. 6.04.)

5 Sec. 271.005. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
6 rate of assessment set by the commissioner may not exceed one
7 percent of the gross premiums subject to assessment under Section
8 271.006.

9 (b) The commissioner shall annually adjust the rate of
10 assessment of the maintenance fee so that the fee imposed that year,
11 together with any unexpended funds produced by the fee, produces
12 the amount the commissioner determines is necessary to pay the
13 expenses during the succeeding year of regulating title insurance.
14 (V.T.I.C. Art. 9.46, Secs. (a) (part), (b) (part), as amended Acts
15 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as
16 amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

17 Sec. 271.006. PREMIUMS SUBJECT TO ASSESSMENT. An insurer
18 shall pay maintenance fees under this chapter on the correctly
19 reported gross premiums from writing title insurance in this state.
20 (V.T.I.C. Art. 9.46, Sec. (a) (part), as amended Acts 73rd Leg.,
21 R.S., Ch. 685, Sec. 3.18.)

22 Sec. 271.007. COLLECTION OF MAINTENANCE FEE. The
23 comptroller shall collect the maintenance fee. (V.T.I.C. Art.
24 9.46, Sec. (a) (part), as amended Acts 73rd Leg., R.S., Ch. 685,
25 Sec. 3.18.)

26 Sec. 271.008. DUTY TO ADVISE COMPTROLLER OF RATE. The
27 commissioner shall advise the comptroller of the applicable rate of

1 assessment of the maintenance fee not later than the 45th day before
2 the due date of the maintenance fee return for the period for which
3 that fee is due. (V.T.I.C. Art. 9.46, Sec. (e) (part), as amended
4 Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18.)

5 Sec. 271.009. EFFECT OF LATE ADVISEMENT OF RATE. (a)
6 Except as provided by Subsection (b), if the commissioner does not
7 advise the comptroller of the applicable rate of assessment of the
8 maintenance fee by the date required by Section 271.008, the rate of
9 assessment is the rate imposed in the preceding period.

10 (b) If the commissioner advises the comptroller of the
11 applicable rate of assessment after the fee has been assessed, the
12 comptroller shall:

13 (1) advise each insurer in writing of the amount of any
14 additional fees due; or

15 (2) refund any excess fees paid. (V.T.I.C. Art. 9.46,
16 Sec. (e) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec.
17 3.18.)

18 Sec. 271.010. DEPOSIT OF MAINTENANCE FEES. (a) The
19 comptroller shall deposit maintenance fees collected under this
20 chapter in the general revenue fund to be reallocated to the Texas
21 Department of Insurance operating account.

22 (b) Amounts in the Texas Department of Insurance operating
23 account may be transferred to the appropriate portion of the
24 general revenue fund in accordance with Section 201.052. (V.T.I.C.
25 Art. 9.46, Sec. (c), as amended Acts 73rd Leg., R.S., Ch. 685, Sec.
26 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S.,
27 Ch. 486, Sec. 6.04.)

1 Sec. 271.011. MAINTENANCE FEE DUE DATES. (a) The insurer
2 shall pay the maintenance fee on an annual, semiannual, or other
3 periodic basis, as determined by the comptroller.

4 (b) The comptroller may require semiannual or other
5 periodic payment only from an insurer whose maintenance fee
6 liability under this chapter for the preceding year was at least
7 \$2,000. (V.T.I.C. Art. 9.46, Secs. (a) (part), (d), as amended Acts
8 73rd Leg., R.S., Ch. 685, Sec. 3.18.)

9 Sec. 271.012. RULES. The commissioner may adopt reasonable
10 rules to implement payments under this chapter. (V.T.I.C. Art.
11 9.46 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

12 [Chapters 272-280 reserved for expansion]

13 SUBTITLE E. OTHER TAXES

14 CHAPTER 281. RETALIATORY PROVISIONS

15 SUBCHAPTER A. RETALIATORY TAXES AND OTHER CHARGES

16 Sec. 281.001. DEFINITIONS

17 Sec. 281.002. TREATMENT OF ALIEN INSURER AS

18 FOREIGN INSURER

19 Sec. 281.003. EXCEPTION

20 Sec. 281.004. RETALIATORY TAXES OR OTHER CHARGES,

21 PROHIBITIONS, AND RESTRICTIONS

22 Sec. 281.005. EXCLUSION OF CERTAIN TAXES OR CHARGES

23 Sec. 281.006. TREATMENT OF CERTAIN TAX REDUCTIONS

24 AND CREDITS

25 Sec. 281.007. TAX REPORT; ADMINISTRATION AND

26 COLLECTION OF TAX

27 [Sections 281.008-281.050 reserved for expansion]

SUBCHAPTER B. RETALIATORY PENALTIES OR OTHER OBLIGATIONS

Sec. 281.051. DEFINITIONS

Sec. 281.052. IMPOSITION OF PENALTY OR OTHER
OBLIGATION

CHAPTER 281. RETALIATORY PROVISIONS

SUBCHAPTER A. RETALIATORY TAXES AND OTHER CHARGES

Sec. 281.001. DEFINITIONS. In this subchapter:

(1) "Domestic insurer" means an insurer organized in
this state.

(2) "Foreign insurer" means an insurer organized in
another state.

(3) "Tax or other charge" includes:

(A) a tax, including an income, corporate
franchise, or maintenance tax;

(B) a fee, including a regulatory fee similar to
a maintenance tax;

(C) a license;

(D) a fine;

(E) a penalty;

(F) a deposit requirement; and

(G) any other obligation. (V.T.I.C. Art. 21.46,
Sec. 1(a) (part).)

Sec. 281.002. TREATMENT OF ALIEN INSURER AS FOREIGN
INSURER. For purposes of this subchapter, an alien insurer is
considered to be organized in the state designated by the insurer in
which the insurer:

(1) has established its principal office or agency in

1 the United States;

2 (2) maintains the greatest amount of its assets held
3 in trust or on deposit for the security of its policyholders or
4 policyholders and creditors in the United States; or

5 (3) was admitted to engage in business in the United
6 States. (V.T.I.C. Art. 21.46, Sec. 1(c).)

7 Sec. 281.003. EXCEPTION. This subchapter does not apply to
8 a person, company, firm, association, group, corporation, or
9 insurance organization of any kind from another state that engages
10 in business in this state if:

11 (1) at least 15 percent of the voting stock of the
12 person, company, firm, association, group, corporation, or
13 insurance organization is owned by a corporation organized under
14 the laws of and domiciled in this state; and

15 (2) the person, company, firm, association, group,
16 corporation, or insurance organization met the requirements of
17 Subdivision (1) before January 30, 1957. (V.T.I.C. Art. 21.46,
18 Sec. (f).)

19 Sec. 281.004. RETALIATORY TAXES OR OTHER CHARGES,
20 PROHIBITIONS, AND RESTRICTIONS. (a) The comptroller shall impose
21 and collect a tax or other charge or a prohibition or restriction on
22 a foreign insurer authorized to engage in business in this state if:

23 (1) the foreign insurer's state of organization by law
24 imposes a tax or other charge or a prohibition or restriction on a
25 similar domestic insurer that is or may be authorized to engage in
26 business in that other state; and

27 (2) the sum of the taxes or other charges,

1 prohibitions, and restrictions imposed by that other state is more
2 than the sum of the taxes or other charges, prohibitions, and
3 restrictions that this state directly imposes on the foreign
4 insurer.

5 (b) The comptroller shall impose and collect the tax or
6 other charge, prohibition, or restriction under Subsection (a) in
7 the same manner and for the same purpose as the foreign insurer's
8 state of organization.

9 (c) The sum of the taxes or other charges that this state
10 imposes on a foreign insurer under this subchapter may not exceed
11 the sum of the taxes or other charges imposed by the foreign
12 insurer's state of organization on a similar domestic insurer that
13 is or may be authorized to engage in business in that other state.
14 (V.T.I.C. Art. 21.46, Sec. 1(a).)

15 Sec. 281.005. EXCLUSION OF CERTAIN TAXES OR CHARGES. In
16 determining an insurer's taxes or other charges under this
17 subchapter, the comptroller may not consider:

18 (1) an ad valorem tax on property;
19 (2) a personal income tax;
20 (3) a sales tax;
21 (4) a surcharge that an insurer may recover directly
22 from policyholders; or

23 (5) an assessment for a special purpose, such as an
24 assessment for a guaranty association, high risk health pool, joint
25 underwriting association, or windstorm association, under the law
26 of this or another state. (V.T.I.C. Art. 21.46, Secs. 1(e), (g)
27 (part).)

1 Sec. 281.006. TREATMENT OF CERTAIN TAX REDUCTIONS AND
2 CREDITS. (a) If another state by law reduces a tax rate or grants a
3 tax credit to a domestic insurer that makes an investment in or
4 maintains offices in that state or that meets a similar
5 requirement, the law that reduces the rate or grants the credit
6 shall be applied in the same manner in this state for the purpose of
7 determining the total taxes or other charges under this subchapter.

8 (b) For purposes of this subchapter, a tax offset or credit
9 related to an assessment described by Section 281.005 is considered
10 a tax paid in this or another state, as appropriate. (V.T.I.C. Art.
11 21.46, Secs. 1(b), (g) (part).)

12 Sec. 281.007. TAX REPORT; ADMINISTRATION AND COLLECTION OF
13 TAX. The comptroller shall prescribe a due date for filing a report
14 and paying a tax imposed under this subchapter. (V.T.I.C. Art.
15 21.46, Sec. 1(d) (part).)

16 [Sections 281.008-281.050 reserved for expansion]

17 SUBCHAPTER B. RETALIATORY PENALTIES OR OTHER OBLIGATIONS

18 Sec. 281.051. DEFINITIONS. In this subchapter:

19 (1) "Domestic insurer" and "foreign insurer" have the
20 meanings assigned by Section 281.001.

21 (2) "Penalty or other obligation" includes a sanction,
22 fine, financial, deposit, or regulatory requirement, and any other
23 obligation, prohibition, or restriction. (V.T.I.C. Art. 21.46,
24 Sec. 2 (part).)

25 Sec. 281.052. IMPOSITION OF PENALTY OR OTHER OBLIGATION.

26 (a) The Texas Department of Insurance shall impose a penalty or
27 other obligation on a foreign insurer authorized to engage in the

business of insurance in this state if:

(1) the insurance department or an insurance regulatory official of the foreign insurer's state of organization imposes a penalty or other obligation on any domestic insurer authorized to engage in the business of insurance in that state; and

(2) the penalty or other obligation is imposed because the Texas Department of Insurance did not:

(A) obtain or maintain accreditation certification or a similar form of approval, compliance, or acceptance from or as a member of the National Association of Insurance Commissioners or a committee, task force, working group, or advisory committee of the association; or

(B) comply with a model act, regulation, report, or requirement of the National Association of Insurance Commissioners or a committee, task force, working group, or advisory committee of the association, including a market conduct, financial examination, or annual financial statement.

(b) A penalty or other obligation imposed by the Texas Department of Insurance on a foreign insurer under this section must be the same as the penalty or other obligation imposed on the domestic insurer by the insurance department or regulatory official of the foreign insurer's state of organization. (V.T.I.C. Art. 21.46, Sec. 2.)

SECTION 2. TITLE 5, INSURANCE CODE. The Insurance Code is amended by adding Title 5 to read as follows:

TITLE 5. PROTECTION OF CONSUMER INTERESTS

SUBTITLE A. PUBLIC INSURANCE COUNSEL

1 CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

2 [Chapters 502-520 reserved for expansion]

3 SUBTITLE B. CONSUMER SERVICE PROVISIONS

4 CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

5 CHAPTER 522. CONSUMER INFORMATION IN SPANISH

6 CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL
7 PROPERTY INSURANCE

8 [Chapters 524-540 reserved for expansion]

9 SUBTITLE C. DECEPTIVE, UNFAIR, AND PROHIBITED PRACTICES

10 CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR
11 DECEPTIVE ACTS OR PRACTICES

12 CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

13 CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY OR
14 CERTIFICATE OF MEMBERSHIP

15 CHAPTER 544. PROHIBITED DISCRIMINATION

16 CHAPTER 545. HIV TESTING

17 CHAPTER 546. USE OF GENETIC TESTING INFORMATION

18 CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

19 CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

20 CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY
21 INSURANCE

22 CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

23 CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION,
24 CANCELLATION, AND NONRENEWAL OF INSURANCE
25 POLICIES

26 CHAPTER 552. ILLEGAL PRICING PRACTICES

27 CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES REGARDING

HOLOCAUST VICTIMS

CHAPTER 554. BURDEN OF PROOF AND PLEADING

CHAPTER 555. FAILURE TO SATISFY JUDGMENT

CHAPTER 556. UNFAIR METHODS OF COMPETITION AND UNFAIR
PRACTICES BY FINANCIAL INSTITUTIONS

CHAPTER 557. INSURED PROPERTY SUBJECT TO SECURITY INTEREST

CHAPTER 558. REFUND OF UNEARNED PREMIUM

[Chapters 559-600 reserved for expansion]

SUBTITLE D. PRIVACY

CHAPTER 601. PRIVACY

CHAPTER 602. PRIVACY OF HEALTH INFORMATION

[Chapters 603-650 reserved for expansion]

SUBTITLE E. PREMIUM FINANCING

CHAPTER 651. FINANCING OF INSURANCE PREMIUMS

[Chapters 652-700 reserved for expansion]

SUBTITLE F. INSURANCE FRAUD

CHAPTER 701. INSURANCE FRAUD INVESTIGATIONS

CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR VEHICLE

INSURANCE FRAUD REPORTING

CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

CHAPTER 704. ANTIFRAUD PROGRAMS

CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS

TITLE 5. PROTECTION OF CONSUMER INTERESTS

SUBTITLE A. PUBLIC INSURANCE COUNSEL

CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 501.001. DEFINITION

1 Sec. 501.002. OFFICE OF PUBLIC INSURANCE COUNSEL

2 Sec. 501.003. SUNSET PROVISION

3 Sec. 501.004. PUBLIC INTEREST INFORMATION

4 Sec. 501.005. ACCESS TO PROGRAMS AND FACILITIES

5 [Sections 501.006-501.050 reserved for expansion]

6 SUBCHAPTER B. PUBLIC COUNSEL

7 Sec. 501.051. APPOINTMENT; TERM

8 Sec. 501.052. QUALIFICATIONS

9 Sec. 501.053. BUSINESS INTEREST; SERVICE AS PUBLIC

10 COUNSEL

11 Sec. 501.054. LOBBYING ACTIVITIES

12 Sec. 501.055. GROUNDS FOR REMOVAL

13 Sec. 501.056. PROHIBITED REPRESENTATION OR EMPLOYMENT

14 [Sections 501.057-501.100 reserved for expansion]

15 SUBCHAPTER C. PERSONNEL

16 Sec. 501.101. OFFICE PERSONNEL

17 Sec. 501.102. TRADE ASSOCIATIONS

18 Sec. 501.103. CAREER LADDER PROGRAM; PERFORMANCE

19 EVALUATIONS

20 Sec. 501.104. EQUAL EMPLOYMENT OPPORTUNITY POLICY;

21 REPORT

22 Sec. 501.105. QUALIFICATIONS AND STANDARDS OF CONDUCT

23 [Sections 501.106-501.150 reserved for expansion]

24 SUBCHAPTER D. POWERS AND DUTIES

25 Sec. 501.151. POWERS AND DUTIES OF OFFICE

26 Sec. 501.152. ADMINISTRATION OF OFFICE

27 Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE,

1 OR INITIATE

2 Sec. 501.154. ACCESS TO INFORMATION

3 Sec. 501.155. RECOMMENDATION OF LEGISLATION

4 Sec. 501.156. CONSUMER BILL OF RIGHTS

5 Sec. 501.157. PROHIBITED INTERVENTIONS OR

6 APPEARANCES

7 Sec. 501.158. CONFIDENTIALITY REQUIREMENTS

8 [Sections 501.159-501.200 reserved for expansion]

9 SUBCHAPTER E. ASSESSMENTS

10 Sec. 501.201. OFFICE EXPENSES

11 Sec. 501.202. ASSESSMENT

12 Sec. 501.203. ASSESSMENT ON PROPERTY AND CASUALTY

13 INSURERS

14 Sec. 501.204. ASSESSMENT ON LIFE, HEALTH, AND ACCIDENT

15 INSURERS AND RELATED ENTITIES

16 Sec. 501.205. ASSESSMENT ON TITLE INSURANCE COMPANIES

17 [Sections 501.206-501.250 reserved for expansion]

18 SUBCHAPTER F. DUTIES RELATING TO HEALTH

19 MAINTENANCE ORGANIZATIONS

20 Sec. 501.251. COMPARISON OF HEALTH MAINTENANCE

21 ORGANIZATIONS

22 Sec. 501.252. ANNUAL CONSUMER REPORT CARDS

23 Sec. 501.253. ACCESS TO INFORMATION

24 Sec. 501.254. CONFIDENTIALITY AND USE OF INFORMATION

25 CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

26 SUBCHAPTER A. GENERAL PROVISIONS

27 Sec. 501.001. DEFINITION. In this chapter, "office" means

1 the office of public insurance counsel. (New.)

2 Sec. 501.002. OFFICE OF PUBLIC INSURANCE COUNSEL. The
3 independent office of public insurance counsel represents the
4 interests of insurance consumers in this state. (V.T.I.C. Art.
5 1.35A, Sec. 1.)

6 Sec. 501.003. SUNSET PROVISION. The office is subject to
7 Chapter 325, Government Code (Texas Sunset Act). Unless continued
8 in existence as provided by that chapter, the office is abolished
9 September 1, 2005. (V.T.I.C. Art. 1.35A, Sec. 7.)

10 Sec. 501.004. PUBLIC INTEREST INFORMATION. (a) The office
11 shall prepare information of public interest describing the
12 functions of the office.

13 (b) The office shall make the information available to the
14 public and appropriate state agencies. (V.T.I.C. Art. 1.35A, Sec.
15 6(a).)

16 Sec. 501.005. ACCESS TO PROGRAMS AND FACILITIES. (a) The
17 office shall prepare and maintain a written plan that describes how
18 a person who does not speak English can be provided reasonable
19 access to the office's programs.

20 (b) The office shall comply with federal and state laws for
21 program and facility accessibility. (V.T.I.C. Art. 1.35A, Sec.
22 6(b).)

23 [Sections 501.006-501.050 reserved for expansion]

24 SUBCHAPTER B. PUBLIC COUNSEL

25 Sec. 501.051. APPOINTMENT; TERM. (a) The governor, with
26 the advice and consent of the senate, shall appoint a public counsel
27 to serve as the executive director of the office. The public

1 counsel serves a two-year term that expires on February 1 of each
2 odd-numbered year.

3 (b) The governor shall appoint the public counsel without
4 regard to the race, color, disability, sex, religion, age, or
5 national origin of the appointee. (V.T.I.C. Art. 1.35A, Secs.
6 2(a), (d), (e), 3(a) (part).)

7 Sec. 501.052. QUALIFICATIONS. To be eligible to serve as
8 public counsel, a person must:

9 (1) be licensed to practice law in this state;

10 (2) have demonstrated a strong commitment to and
11 involvement in efforts to safeguard the rights of the public; and

12 (3) possess the knowledge and experience necessary to
13 practice effectively in insurance proceedings. (V.T.I.C. Art.
14 1.35A, Sec. 2(b).)

15 Sec. 501.053. BUSINESS INTEREST; SERVICE AS PUBLIC COUNSEL.
16 A person is not eligible for appointment as public counsel if the
17 person or the person's spouse:

18 (1) is employed by or participates in the management
19 of a business entity or other organization regulated by or
20 receiving funds from the department;

21 (2) owns or controls, directly or indirectly, more
22 than a 10 percent interest in a business entity or other
23 organization regulated by or receiving funds from the department or
24 the office; or

25 (3) uses or receives a substantial amount of tangible
26 goods, services, or funds from the department or the office, other
27 than compensation or reimbursement authorized by law for department

1 or office membership, attendance, or expenses. (V.T.I.C. Art.
2 1.35A, Sec. 2(c).)

3 Sec. 501.054. LOBBYING ACTIVITIES. A person may not serve
4 as public counsel or act as general counsel to the office if the
5 person is required to register as a lobbyist under Chapter 305,
6 Government Code, because of the person's activities for
7 compensation related to the operation of the department or the
8 office. (V.T.I.C. Art. 1.35A, Sec. 4(a).)

9 Sec. 501.055. GROUNDS FOR REMOVAL. (a) It is a ground for
10 removal from office if the public counsel:

11 (1) does not have at the time of appointment or
12 maintain during service as public counsel the qualifications
13 required by Section 501.052;

14 (2) violates a prohibition established by Section
15 501.053, 501.054, 501.056, or 501.102; or

16 (3) cannot, because of illness or disability,
17 discharge the public counsel's duties for a substantial part of the
18 public counsel's term.

19 (b) The validity of an action of the office is not affected
20 by the fact that the action is taken when a ground for removal of the
21 public counsel exists. (V.T.I.C. Art. 1.35A, Secs. 2(f), (g).)

22 Sec. 501.056. PROHIBITED REPRESENTATION OR EMPLOYMENT. A
23 former public counsel may not represent any person or receive
24 compensation for services rendered on behalf of any person
25 regarding a case pending before the commissioner or department
26 before the second anniversary of the date the person ceases to serve
27 as public counsel. (V.T.I.C. Art. 1.35A, Sec. 4(b).)

[Sections 501.057-501.100 reserved for expansion]

SUBCHAPTER C. PERSONNEL

Sec. 501.101. OFFICE PERSONNEL. (a) The public counsel shall employ professional, technical, and other employees necessary to implement this chapter.

(b) Compensation for an employee shall be set under the General Appropriations Act as provided by the legislature. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Sec. 501.102. TRADE ASSOCIATIONS. (a) In this section, "trade association" means a nonprofit, cooperative, and voluntarily joined association of business or professional competitors designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(b) A person may not serve as public counsel or be an employee of the office who is exempt from the state's position classification plan or is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group A17, of the position classification salary schedule if the person is:

(1) an officer, employee, or paid consultant of a trade association in the field of insurance; or

(2) the spouse of an officer, manager, or paid consultant of a trade association in the field of insurance. (V.T.I.C. Art. 1.35A, Secs. 4(c), (d), (e).)

Sec. 501.103. CAREER LADDER PROGRAM; PERFORMANCE EVALUATIONS. (a) The public counsel or the public counsel's

1 designee shall develop an intra-agency career ladder program. The
2 program must require intra-agency posting of all nonentry level
3 positions concurrently with any public posting.

4 (b) The public counsel or the public counsel's designee
5 shall develop a system of annual performance evaluations. All
6 merit pay for office employees must be based on the system
7 established under this subsection. (V.T.I.C. Art. 1.35A, Secs.
8 3(g), (h).)

9 Sec. 501.104. EQUAL EMPLOYMENT OPPORTUNITY POLICY; REPORT.

10 (a) The public counsel or the public counsel's designee shall
11 prepare and maintain a written policy statement to ensure
12 implementation of an equal employment opportunity program under
13 which all personnel transactions are made without regard to race,
14 color, disability, sex, religion, age, or national origin. The
15 policy statement must include:

16 (1) personnel policies, including policies relating
17 to recruitment, evaluation, selection, appointment, training, and
18 promotion of personnel that are in compliance with the requirements
19 of Chapter 21, Labor Code;

20 (2) a comprehensive analysis of the office workforce
21 that meets federal and state guidelines;

22 (3) procedures by which a determination can be made
23 about areas of significant underuse in the office workforce of all
24 persons for whom federal or state guidelines encourage a more
25 equitable balance; and

26 (4) reasonable methods to appropriately address those
27 areas of significant underuse.

1 (b) A policy statement prepared under Subsection (a) must:
2 (1) cover an annual period;
3 (2) be updated at least annually;
4 (3) be reviewed by the Commission on Human Rights for
5 compliance with Subsection (a)(1); and
6 (4) be filed with the governor.

7 (c) The governor shall deliver a biennial report to the
8 legislature based on the information received under Subsection (b).
9 The report may be made separately or as a part of other biennial
10 reports to the legislature. (V.T.I.C. Art. 1.35A, Secs. 3(d), (e),
11 (f).)

12 Sec. 501.105. QUALIFICATIONS AND STANDARDS OF CONDUCT. The
13 office shall provide to the public counsel and office employees, as
14 often as necessary, information regarding their:

15 (1) qualifications for office or employment under this
16 chapter; and

17 (2) responsibilities under applicable laws relating
18 to standards of conduct for state officers or employees. (V.T.I.C.
19 Art. 1.35A, Sec. 3(i).)

20 [Sections 501.106-501.150 reserved for expansion]

21 SUBCHAPTER D. POWERS AND DUTIES

22 Sec. 501.151. POWERS AND DUTIES OF OFFICE. The office:

23 (1) may assess the impact of insurance rates, rules,
24 and forms on insurance consumers in this state; and

25 (2) shall advocate in the office's own name positions
26 determined by the public counsel to be most advantageous to a
27 substantial number of insurance consumers. (V.T.I.C. Art. 1.35A,

1 Sec. 5(a).)

2 Sec. 501.152. ADMINISTRATION OF OFFICE. The public counsel
3 shall administer and enforce this chapter, including preparing and
4 submitting to the legislature a budget for the office and approving
5 expenditures for professional services, travel, per diem, and other
6 actual and necessary expenses incurred in administering the office.
7 (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

8 Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE.
9 The public counsel:

10 (1) may appear or intervene, as a party or otherwise,
11 as a matter of right before the commissioner or department on behalf
12 of insurance consumers, as a class, in matters involving:

13 (A) rates, rules, and forms affecting:

14 (i) property and casualty insurance;

15 (ii) title insurance;

16 (iii) credit life insurance;

17 (iv) credit accident and health insurance;

18 or

19 (v) any other line of insurance for which
20 the commissioner or department promulgates, sets, adopts, or
21 approves rates, rules, or forms;

22 (B) rules affecting life, health, or accident
23 insurance; or

24 (C) withdrawal of approval of policy forms:

25 (i) in proceedings initiated by the
26 department under Sections 1701.055 and 1701.057; or

27 (ii) if the public counsel presents

1 persuasive evidence to the department that the forms do not comply
2 with this code, a rule adopted under this code, or any other law;

3 (2) may initiate or intervene as a matter of right or
4 otherwise appear in a judicial proceeding involving or arising from
5 an action taken by an administrative agency in a proceeding in which
6 the public counsel previously appeared under the authority granted
7 by this chapter;

8 (3) may appear or intervene, as a party or otherwise,
9 as a matter of right on behalf of insurance consumers as a class in
10 any proceeding in which the public counsel determines that
11 insurance consumers are in need of representation, except that the
12 public counsel may not intervene in an enforcement or parens
13 patriae proceeding brought by the attorney general; and

14 (4) may appear or intervene before the commissioner or
15 department as a party or otherwise on behalf of small commercial
16 insurance consumers, as a class, in a matter involving rates,
17 rules, or forms affecting commercial insurance consumers, as a
18 class, in any proceeding in which the public counsel determines
19 that small commercial consumers are in need of representation.
20 (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

21 Sec. 501.154. ACCESS TO INFORMATION. The public counsel:

22 (1) is entitled to the same access as a party, other
23 than department staff, to department records available in a
24 proceeding before the commissioner or department under the
25 authority granted to the public counsel by this chapter; and

26 (2) is entitled to obtain discovery under Chapter
27 2001, Government Code, of any nonprivileged matter that is relevant

1 to the subject matter involved in a proceeding or submission before
2 the commissioner or department as authorized by this chapter.
3 (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

4 Sec. 501.155. RECOMMENDATION OF LEGISLATION. The public
5 counsel may recommend legislation to the legislature that the
6 public counsel determines would positively affect the interests of
7 insurance consumers. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

8 Sec. 501.156. CONSUMER BILL OF RIGHTS. The public counsel
9 shall submit to the department for adoption a consumer bill of
10 rights appropriate to each personal line of insurance regulated by
11 the department to be distributed on issuance of a policy by an
12 insurer to each policyholder under department rules. (V.T.I.C. Art.
13 1.35A, Sec. 5(b) (part).)

14 Sec. 501.157. PROHIBITED INTERVENTIONS OR APPEARANCES. The
15 public counsel may not intervene or appear in:

16 (1) any proceeding or hearing before the commissioner
17 or department, or any other proceeding, that relates to approval or
18 consideration of an individual charter, license, certificate of
19 authority, acquisition, merger, or examination; or

20 (2) any proceeding concerning the solvency of an
21 individual insurer, a financial issue, a policy form, advertising,
22 or another regulatory issue affecting an individual insurer or
23 agent. (V.T.I.C. Art. 1.35A, Sec. 5(c) (part).)

24 Sec. 501.158. CONFIDENTIALITY REQUIREMENTS.
25 Confidentiality requirements applicable to examination reports
26 under Article 1.18 and to the commissioner under Section 3A,
27 Article 21.28-A, apply to the public counsel. (V.T.I.C. Art.

1 1.35A, Sec. 5(c) (part).)

2 [Sections 501.159-501.200 reserved for expansion]

3 SUBCHAPTER E. ASSESSMENTS

4 Sec. 501.201. OFFICE EXPENSES. Expenses of the office
5 shall be paid from the assessments collected under this subchapter.
6 (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

7 Sec. 501.202. ASSESSMENT. To defray the costs of operating
8 the office, the comptroller shall collect assessments under this
9 subchapter annually in connection with the collection of other
10 taxes imposed on an insurer. (V.T.I.C. Art. 1.35B, Sec. (a)
11 (part).)

12 Sec. 501.203. ASSESSMENT ON PROPERTY AND CASUALTY INSURERS.
13 Each property and casualty insurer authorized to engage in business
14 in this state shall pay an annual assessment of 5.7 cents for each
15 property and casualty insurance policy in force in this state at the
16 end of the year. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

17 Sec. 501.204. ASSESSMENT ON LIFE, HEALTH, AND ACCIDENT
18 INSURERS AND RELATED ENTITIES. (a) This section applies to each
19 insurer authorized to engage in business in this state under:

- 20 (1) Chapter 25;
- 21 (2) Chapter 841;
- 22 (3) Chapter 842;
- 23 (4) Chapter 843;
- 24 (5) Chapter 882;
- 25 (6) Chapter 884;
- 26 (7) Chapter 885;
- 27 (8) Chapter 887;

- 1 (9) Chapter 888;
2 (10) Chapter 961;
3 (11) Chapter 982;
4 (12) Subchapter B, Chapter 1103;
5 (13) Subchapter A, Chapter 1104;
6 (14) Chapter 1201, or a provision listed in Section
7 1201.005;
8 (15) Chapter 1551;
9 (16) Chapter 1578; or
10 (17) Chapter 1601.

11 (b) Each insurer subject to this section shall pay an annual
12 assessment of 5.7 cents for each individual policy, and for each
13 certificate of insurance evidencing coverage under a group policy,
14 of life, health, or accident insurance that is written for delivery
15 and placed in force in this state during each calendar year and for
16 which the initial premium is paid in full. (V.T.I.C. Art. 1.35B,
17 Sec. (a) (part).)

18 Sec. 501.205. ASSESSMENT ON TITLE INSURANCE COMPANIES.
19 Each title insurance company authorized to engage in business in
20 this state shall pay an annual assessment of 5.7 cents for each
21 owner and mortgage policy that is written for delivery in this state
22 during each calendar year and for which the full basic premium is
23 charged. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

24 [Sections 501.206-501.250 reserved for expansion]

25 SUBCHAPTER F. DUTIES RELATING TO HEALTH

26 MAINTENANCE ORGANIZATIONS

27 Sec. 501.251. COMPARISON OF HEALTH MAINTENANCE

1 ORGANIZATIONS. (a) The office shall develop and implement a system
2 to compare and evaluate, on an objective basis, the quality of care
3 provided by and the performance of health maintenance organizations
4 established under Chapter 843.

5 (b) In developing the system, the office may use information
6 or data from a person, agency, organization, or governmental unit
7 that the office considers reliable. (V.T.I.C. Art. 1.35A, Sec.
8 5(e) (part).)

9 Sec. 501.252. ANNUAL CONSUMER REPORT CARDS. (a) The office
10 shall develop and issue annual consumer report cards that identify
11 and compare, on an objective basis, health maintenance
12 organizations in this state. The consumer report cards may be based
13 on information or data from any person, agency, organization, or
14 governmental unit that the office considers reliable.

15 (b) The office may not endorse or recommend a specific
16 health maintenance organization or plan, or subjectively rate or
17 rank health maintenance organizations or plans, other than through
18 comparison and evaluation of objective criteria.

19 (c) The office shall provide a copy of any consumer report
20 card on request on payment of a reasonable fee. (V.T.I.C. Art.
21 1.35A, Secs. 5(e)(2), (10), (11).)

22 Sec. 501.253. ACCESS TO INFORMATION. (a) The office is
23 entitled to information that is confidential under a law of this
24 state, including Section 843.006 of this code, Chapter 108, Health
25 and Safety Code, and Chapter 552, Government Code.

26 (b) The department and the Texas Health Care Information
27 Council shall provide any information or data as requested by the

1 office in furtherance of the duties under this subchapter.

2 (c) The office shall use information collected or received
3 under this subchapter for the benefit of the public. (V.T.I.C. Art.
4 1.35A, Secs. 5(e)(3), (4) (part), (5).)

5 Sec. 501.254. CONFIDENTIALITY AND USE OF INFORMATION. (a)
6 Except as provided by this section, information collected under
7 this subchapter is subject to Chapter 552, Government Code, and the
8 office shall make determinations on requests for information in
9 favor of access.

10 (b) The office may not make public any confidential
11 information provided to the office under this subchapter but may
12 disclose a summary of the information that does not directly or
13 indirectly identify the health maintenance organization that is the
14 subject of the information. The office may not release, and a
15 person or entity may not gain access to, any information that:

16 (1) could reasonably be expected to reveal the
17 identity of a patient or physician;

18 (2) reveals the zip code of a patient's primary
19 residence;

20 (3) discloses a provider discount or a differential
21 between a payment and a billed charge; or

22 (4) relates to an actual payment made by a payer to an
23 identified provider.

24 (c) Information collected or used by the office under this
25 subchapter is subject to the confidentiality provisions and
26 criminal penalties of:

27 (1) Section 81.103, Health and Safety Code;

(2) Section 311.037, Health and Safety Code; and

(3) Chapter 159, Occupations Code.

(d) Information on patients and physicians that is in the possession of the office and any compilation, report, or analysis produced from the information that identifies patients and physicians is not:

(1) subject to discovery, subpoena, or other means of legal compulsion for release to any person or entity; or

(2) admissible in any civil, administrative, or criminal proceeding.

(e) Notwithstanding Subsection (b)(2), the office may use zip code information to analyze information on a geographical basis. (V.T.I.C. Art. 1.35A, Secs. 5(e)(4) (part), (6), (7), (8), (9).)

[Chapters 502-520 reserved for expansion]

SUBTITLE B. CONSUMER SERVICE PROVISIONS

CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

SUBCHAPTER A. PUBLIC INTEREST INFORMATION AND

COMPLAINT PROCEDURES

Sec. 521.001. PUBLIC INTEREST INFORMATION

Sec. 521.002. COMPLAINT RESOLUTION PROGRAM

Sec. 521.003. NOTIFICATION OF COMPLAINT STATUS

Sec. 521.004. RECORDS OF COMPLAINTS

Sec. 521.005. NOTICE TO ACCOMPANY POLICY

[Sections 521.006-521.050 reserved for expansion]

SUBCHAPTER B. DEPARTMENT TOLL-FREE NUMBER FOR

INFORMATION AND COMPLAINTS

1 Sec. 521.051. DEPARTMENT TOLL-FREE NUMBER FOR

2 INFORMATION AND COMPLAINTS

3 Sec. 521.052. INFORMATION PROVIDED

4 Sec. 521.053. PUBLICITY REQUIREMENTS

5 Sec. 521.054. RECORD OF INQUIRY OR COMPLAINT REQUIRED

6 Sec. 521.055. COMPLAINT NOTIFICATION SYSTEM

7 Sec. 521.056. INFORMATION BULLETIN TO ACCOMPANY POLICY

8 [Sections 521.057-521.100 reserved for expansion]

9 SUBCHAPTER C. HEALTH MAINTENANCE ORGANIZATION OR

10 INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

11 Sec. 521.101. APPLICABILITY OF SUBCHAPTER

12 Sec. 521.102. HEALTH MAINTENANCE ORGANIZATION OR INSURER

13 TOLL-FREE NUMBER FOR INFORMATION AND

14 COMPLAINTS

15 Sec. 521.103. INFORMATION INCLUDED IN EVIDENCE OF COVERAGE

16 OR POLICY

17 CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

18 SUBCHAPTER A. PUBLIC INTEREST INFORMATION AND

19 COMPLAINT PROCEDURES

20 Sec. 521.001. PUBLIC INTEREST INFORMATION. (a) The
21 department shall prepare information of public interest describing
22 the department's functions and the procedures by which complaints
23 are filed with and resolved by the department.

24 (b) The department shall make the information available to
25 the public and appropriate state agencies. (V.T.I.C. Art. 1.37.)

26 Sec. 521.002. COMPLAINT RESOLUTION PROGRAM. The department
27 shall establish a program to facilitate resolution of policyholder

1 complaints. (V.T.I.C. Art. 1.04B.)

2 Sec. 521.003. NOTIFICATION OF COMPLAINT STATUS. If a
3 written complaint is filed with the department, the department, at
4 least quarterly and until final disposition of the complaint, shall
5 notify each party to the complaint of the complaint's status unless
6 the notice would jeopardize an undercover investigation. (V.T.I.C.
7 Art. 1.10, Sec. 19.)

8 Sec. 521.004. RECORDS OF COMPLAINTS. The department shall
9 keep an information file about each complaint filed with the
10 department that concerns an activity regulated by the department or
11 the commissioner. (V.T.I.C. Art. 1.10, Sec. 18.)

12 Sec. 521.005. NOTICE TO ACCOMPANY POLICY. (a) Each
13 insurance policy delivered or issued for delivery in this state
14 shall include with the policy a brief written notice that includes:

15 (1) a suggested procedure to be followed by a
16 policyholder with a dispute concerning the policyholder's claim or
17 premium;

18 (2) the department's name and address; and

19 (3) the department's toll-free telephone number
20 maintained under Subchapter B.

21 (b) The commissioner shall adopt appropriate wording for
22 the notice. (V.T.I.C. Art. 1.35.)

23 [Sections 521.006-521.050 reserved for expansion]

24 SUBCHAPTER B. DEPARTMENT TOLL-FREE NUMBER FOR
25 INFORMATION AND COMPLAINTS

26 Sec. 521.051. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION
27 AND COMPLAINTS. The department shall maintain a toll-free

1 telephone number to:

2 (1) provide the information described by Section
3 521.052; and

4 (2) receive and aid in resolving complaints against
5 insurers. (V.T.I.C. Art. 1.35D, Sec. (a).)

6 Sec. 521.052. INFORMATION PROVIDED. The department shall
7 provide to the public through the department's toll-free telephone
8 number only the following information:

9 (1) information collected or maintained by the
10 department relating to the number and disposition of complaints
11 received against an insurer that are justified, verified as
12 accurate, and documented as valid, expressed as a percentage of the
13 total number of insurance policies written by the insurer and in
14 force on December 31 of the preceding year;

15 (2) the rating of an insurer, if any, as published by a
16 nationally recognized rating organization;

17 (3) the kinds of coverage available to a consumer
18 through any insurer writing insurance in this state;

19 (4) an insurer's admitted assets-to-liabilities
20 ratio; and

21 (5) other appropriate information collected and
22 maintained by the department. (V.T.I.C. Art. 1.35D, Sec. (b).)

23 Sec. 521.053. PUBLICITY REQUIREMENTS. The department shall
24 publicize the department's toll-free telephone number in public
25 service announcements and publish that number in telephone books
26 throughout the state, as the department finds appropriate.
27 (V.T.I.C. Art. 1.35D, Sec. (e).)

1 Sec. 521.054. RECORD OF INQUIRY OR COMPLAINT REQUIRED. The
2 department shall maintain a written record of each inquiry and
3 complaint received through the department's toll-free telephone
4 number. (V.T.I.C. Art. 1.35D, Sec. (c).)

5 Sec. 521.055. COMPLAINT NOTIFICATION SYSTEM. The
6 department shall establish a system to notify insurers by
7 electronic transmission to a facsimile machine or other appropriate
8 system of complaints received by the department through the
9 department's toll-free telephone number. (V.T.I.C. Art. 1.35D,
10 Sec. (d).)

11 Sec. 521.056. INFORMATION BULLETIN TO ACCOMPANY POLICY.
12 Each insurer that delivers, issues for delivery, or renews an
13 insurance policy in this state shall include with the policy an
14 information bulletin that includes:

- 15 (1) the department's toll-free telephone number; and
16 (2) a description of the services available through
17 the department's toll-free telephone number. (V.T.I.C. Art. 1.35D,
18 Sec. (f).)

19 [Sections 521.057-521.100 reserved for expansion]

20 SUBCHAPTER C. HEALTH MAINTENANCE ORGANIZATION OR
21 INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

22 Sec. 521.101. APPLICABILITY OF SUBCHAPTER. (a) Except as
23 provided by Subsection (b), this subchapter applies to a health
24 maintenance organization authorized to engage in the business of a
25 health maintenance organization in this state or an insurer
26 authorized to engage in the business of insurance in this state,
27 including:

- (1) a capital stock insurance company;
- (2) a mutual insurance company;
- (3) a title insurance company;
- (4) a fraternal benefit society;
- (5) a local mutual aid association;
- (6) a statewide mutual assessment company;
- (7) a county mutual insurance company;
- (8) a Lloyd's plan;
- (9) a reciprocal or interinsurance exchange;
- (10) a stipulated premium company;
- (11) a group hospital service corporation; and
- (12) a risk retention group.

(b) This subchapter does not apply to a health maintenance organization or insurer:

(1) that has gross initial premium receipts collected in this state of less than \$2 million each year; or

(2) with regard to fidelity, surety, or guaranty bonds. (V.T.I.C. Art. 21.71, Secs. (a), (b).)

Sec. 521.102. HEALTH MAINTENANCE ORGANIZATION OR INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS. A health maintenance organization or insurer shall maintain a toll-free telephone number to:

(1) provide information concerning evidences of coverage or policies issued by the health maintenance organization or insurer; and

(2) receive complaints from enrollees or policyholders. (V.T.I.C. Art. 21.71, Sec. (c).)

1 Sec. 521.103. INFORMATION INCLUDED IN EVIDENCE OF COVERAGE
2 OR POLICY. (a) Each health maintenance organization or insurer
3 that delivers, issues for delivery, or renews an evidence of
4 coverage or insurance policy in this state shall print on the
5 evidence of coverage or policy the health maintenance
6 organization's or insurer's toll-free telephone number.

7 (b) The commissioner may adopt rules governing the manner in
8 which the toll-free telephone number appears on the evidence of
9 coverage or insurance policy. (V.T.I.C. Art. 21.71, Sec. (d).)

10 CHAPTER 522. CONSUMER INFORMATION IN SPANISH

11 Sec. 522.001. INFORMATIONAL SHEET FOR TEXAS PERSONAL

12 AUTOMOBILE POLICIES

13 CHAPTER 522. CONSUMER INFORMATION IN SPANISH

14 Sec. 522.001. INFORMATIONAL SHEET FOR TEXAS PERSONAL
15 AUTOMOBILE POLICIES. (a) The commissioner shall develop or adopt
16 an informational sheet in the Spanish language to provide a general
17 explanation of the terms most commonly used in the Texas personal
18 automobile insurance policy. The department shall make the
19 informational sheet available to the public.

20 (b) The informational sheet is intended to provide only a
21 general explanation of insurance terms used in the Texas personal
22 automobile insurance policy and is not intended to alter any
23 rights, obligations, or responsibilities of the contracting
24 parties. All other applicable laws, including provisions of this
25 code, apply regardless of whether an informational sheet is used.

26 (c) The informational sheet must include a disclaimer in the
27 Spanish language, prominently printed in 10-point boldfaced type at

the top of the informational sheet, that contains the following:

"This document is for informational purposes only and is not intended to alter or replace the insurance policy. Additionally, this informational sheet is not intended to fully set out your rights and obligations or the rights and obligations of the insurer. If you have questions about your insurance, you should consult your insurance agent, the insurer, or the language of the insurance policy." (V.T.I.C. Art. 1.35E.)

CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL
PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 523.001. DEFINITION

Sec. 523.002. RULES

Sec. 523.003. IMMUNITY

[Sections 523.004-523.050 reserved for expansion]

SUBCHAPTER B. OPERATION OF MARKET ASSISTANCE PROGRAM

Sec. 523.051. MARKET ASSISTANCE PROGRAM

Sec. 523.052. MARKET ASSISTANCE PROGRAM DIVISION

Sec. 523.053. EXECUTIVE COMMITTEE

Sec. 523.054. PLAN OF OPERATION

Sec. 522.055. AMENDMENT OF PLAN OF OPERATION

[Sections 523.056-523.100 reserved for expansion]

SUBCHAPTER C. PARTICIPATION IN MARKET ASSISTANCE
PROGRAM

Sec. 523.101. PARTICIPATION BY INSURERS

1 Sec. 523.102. APPLICATION ASSISTANCE AND REFERRALS

2 Sec. 523.103. APPLICATION FOR ASSISTANCE

3 Sec. 523.104. INSURER ACTION ON APPLICATION

4 Sec. 523.105. NONPAYMENT OF PREMIUM OR SUBMISSION OF
5 FRAUDULENT CLAIM

6 [Sections 523.106-523.150 reserved for expansion]

7 SUBCHAPTER D. PROGRAM AGENTS

8 Sec. 523.151. TYPES OF AGENTS

9 Sec. 523.152. SHARING OF AGENT COMMISSIONS

10 [Sections 523.153-523.200 reserved for expansion]

11 SUBCHAPTER E. MARKET ASSISTANCE PROGRAM REVIEW;

12 PROGRAM TERMINATION

13 Sec. 523.201. COLLECTION OF PROGRAM INFORMATION

14 Sec. 523.202. PERIODIC REVIEW OF PROGRAM

15 Sec. 523.203. TERMINATION OF PROGRAM

16 CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL

17 PROPERTY INSURANCE

18 SUBCHAPTER A. GENERAL PROVISIONS

19 Sec. 523.001. DEFINITION. In this chapter, "residential
20 property insurance" means insurance provided by a homeowners policy
21 or residential fire and allied lines policy against loss incurred
22 at a fixed location to real or tangible personal property. The term
23 does not include insurance against loss provided by a farm and ranch
24 owners policy. (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

25 Sec. 523.002. RULES. In addition to the plan of operation
26 adopted under Subchapter B, the commissioner may adopt appropriate
27 rules to accomplish the purposes of this chapter. (V.T.I.C. Art.

21.49-12, Sec. 8.)

Sec. 523.003. IMMUNITY. The market assistance program, the members of the executive committee, and participating insurers and agents are not personally liable for:

(1) an act performed in good faith in the scope of the person's authority as determined under this chapter; or

(2) damages arising from the person's official acts or omissions, other than a corrupt or malicious act or omission. (V.T.I.C. Art. 21.49-12, Sec. 7.)

[Sections 523.004-523.050 reserved for expansion]

SUBCHAPTER B. OPERATION OF MARKET ASSISTANCE PROGRAM

Sec. 523.051. MARKET ASSISTANCE PROGRAM. (a) The market assistance program is a voluntary program designed to assist applicants for insurance and insureds in this state in obtaining residential property insurance coverage in underserved areas. The commissioner by rule shall designate underserved areas using the standards described by Section 1, Article 5.35-3.

(b) The commissioner shall establish the types of risks for which the market assistance program will provide assistance.

(c) The market assistance program may not provide assistance regarding windstorm and hail insurance coverage for a risk eligible for that coverage under Article 21.49. (V.T.I.C. Art. 21.49-12, Secs. 1(a) (part), (b).)

Sec. 523.052. MARKET ASSISTANCE PROGRAM DIVISION. The department shall operate a market assistance program division. (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

Sec. 523.053. EXECUTIVE COMMITTEE. (a) The market

1 assistance program is administered by an executive committee.

2 (b) The executive committee consists of 11 members
3 appointed by the commissioner as follows:

4 (1) five members who represent the interests of
5 insurers;

6 (2) four public members; and

7 (3) two members who are general property and casualty
8 agents.

9 (c) Each member of the executive committee who represents
10 the interests of insurers must be a full-time employee of an
11 authorized insurer.

12 (d) The commissioner or the commissioner's designated
13 representative serves as an ex officio member of the executive
14 committee and must be present at each executive committee meeting.

15 (e) The executive committee shall be available to advise and
16 consult with the commissioner regarding the administration of the
17 market assistance program. (V.T.I.C. Art. 21.49-12, Secs. 2(a)
18 (part), 3.)

19 Sec. 523.054. PLAN OF OPERATION. (a) The operation and
20 management of the market assistance program is governed by a plan of
21 operation adopted by rule by the commissioner.

22 (b) In addition to the other requirements specified by this
23 chapter, the plan of operation must include provisions regarding
24 types of coverage, policy forms and terms, application forms,
25 eligibility, and the overall operation of the market assistance
26 program.

27 (c) The plan of operation may provide for subcommittees

1 necessary to administer the market assistance program. (V.T.I.C.
2 Art. 21.49-12, Secs. 2(a) (part), (b) (part), (c).)

3 Sec. 523.055. AMENDMENT OF PLAN OF OPERATION. (a) The
4 executive committee may develop amendments to the plan of operation
5 and submit the amendments to the commissioner for adoption by rule.

6 (b) If the executive committee fails to submit suitable
7 amendments to the plan of operation, the department shall develop
8 and submit to the commissioner suitable amendments and the
9 commissioner shall, after notice and hearing, adopt the amendments
10 by rule. (V.T.I.C. Art. 21.49-12, Sec. 2(a) (part).)

11 [Sections 523.056-523.100 reserved for expansion]

12 SUBCHAPTER C. PARTICIPATION IN MARKET ASSISTANCE PROGRAM

13 Sec. 523.101. PARTICIPATION BY INSURERS. (a) An insurer
14 authorized to engage in the business of property or casualty
15 insurance that writes residential property insurance in this state,
16 including a Lloyd's plan or a reciprocal or interinsurance
17 exchange, may voluntarily participate in the market assistance
18 program. The commissioner may not permit an insurer to condition
19 its participation in the program in a manner that is inequitable to
20 the participants.

21 (b) Notwithstanding Subsection (a), the commissioner may
22 make insurer participation in the market assistance program
23 mandatory. The plan of operation must contain the criteria under
24 which the commissioner may make insurer participation in the market
25 assistance program mandatory.

26 (c) Each participating insurer is entitled to individually
27 evaluate a risk and apply rates under the market assistance program

1 in accordance with the provisions of this code applicable to the
2 insurer. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), (b) (part).)

3 Sec. 523.102. APPLICATION ASSISTANCE AND REFERRALS. The
4 department may:

5 (1) assist an applicant for coverage through the
6 market assistance program in completing an initial application; and

7 (2) refer the applicant to one or more participating
8 insurers. (V.T.I.C. Art. 21.49-12, Sec. 4(a).)

9 Sec. 523.103. APPLICATION FOR ASSISTANCE. (a) An
10 application for assistance must be addressed to the market
11 assistance program at the department.

12 (b) An application must be accompanied by a copy of a
13 current notice of nonrenewal or cancellation of coverage and a
14 current declination letter from at least one other insurer that
15 writes the coverage sought, except that an applicant who does not
16 have previous residential property insurance coverage must provide
17 copies of current declination letters from at least two
18 unaffiliated insurers that write the coverage sought. (V.T.I.C.
19 Art. 21.49-12, Sec. 2(b) (part).)

20 Sec. 523.104. INSURER ACTION ON APPLICATION. (a) Not later
21 than the 30th day after the date an insurer receives an application,
22 the insurer shall:

23 (1) quote a premium;
24 (2) indicate its refusal to quote a premium; or
25 (3) request additional time to consider a premium
26 quote.

27 (b) If the insurer quotes a premium, the insurer shall

1 notify the applicant or the applicant's agent, if an agent is used,
2 so that the placement of the insurance may be completed if the
3 applicant accepts the coverage at the quoted premium.

4 (c) The insurer may provide a premium quote on the same
5 coverage basis for which the insurer normally provides insurance in
6 this state using the insurer's underwriting guidelines and applying
7 rates determined in accordance with the provisions of this code
8 applicable to the insurer. (V.T.I.C. Art. 21.49-12, Sec. 2(b)
9 (part).)

10 Sec. 523.105. NONPAYMENT OF PREMIUM OR SUBMISSION OF
11 FRAUDULENT CLAIM. If an insurer cancels or does not renew coverage
12 for nonpayment of premium or submission of a fraudulent claim, an
13 applicant is ineligible to subsequently apply to the market
14 assistance program for the same coverage for the same risk.
15 (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

16 [Sections 523.106-523.150 reserved for expansion]

17 SUBCHAPTER D. PROGRAM AGENTS

18 Sec. 523.151. TYPES OF AGENTS. (a) Notwithstanding other
19 law, the market assistance program may have both originating agents
20 and issuing agents.

21 (b) An originating agent may complete on behalf of an
22 applicant an application for insurance to submit to the market
23 assistance program. An applicant is not required to submit the
24 application through an originating agent. If an originating agent
25 is used, the originating agent is not required to be appointed to
26 represent the ultimate insurer.

27 (c) An issuing agent must be appointed to represent the

ultimate insurer. The issuing agent shall perform the customary duties of a general property and casualty agent, including:

(1) signing, executing, and delivering insurance policies;

(2) maintaining a record of the business;

(3) examining and inspecting the risk; and

(4) receiving and collecting premiums.

(d) A person may act as both the originating agent and the issuing agent. If the originating agent and the issuing agent are not the same person, the originating agent may not be held to be the agent of the insurer unless the agent is appointed as provided by Chapter 4051. (V.T.I.C. Art. 21.49-12, Secs. 4(b), (c), (d), (f).)

Sec. 523.152. SHARING OF AGENT COMMISSIONS. (a) An originating agent shall share commissions with an issuing agent as required by the market assistance program plan of operation if the originating agent holds a license as:

(1) a general property and casualty agent; or

(2) a salaried representative for one or more insurers whose plan of operation does not contemplate the use of general property and casualty agents.

(b) The market assistance program may not share in commissions. (V.T.I.C. Art. 21.49-12, Secs. 4(e), (g).)

[Sections 523.153-523.200 reserved for expansion]

SUBCHAPTER E. MARKET ASSISTANCE PROGRAM REVIEW;

PROGRAM TERMINATION

Sec. 523.201. COLLECTION OF PROGRAM INFORMATION. Information concerning the number and type of applications received

1 and placed by the market assistance program and other information
2 about the program the executive committee or the commissioner
3 considers appropriate shall be collected. (V.T.I.C. Art. 21.49-12,
4 Sec. 6(a).)

5 Sec. 523.202. PERIODIC REVIEW OF PROGRAM. (a) The
6 executive committee shall review the demand for and performance of
7 the market assistance program at least annually, as necessary.

8 (b) After each review, the executive committee shall report
9 to the commissioner regarding:

10 (1) the need to continue operating the voluntary
11 market assistance program;

12 (2) the need to establish a mandatory market
13 assistance program;

14 (3) the need to establish a FAIR (Fair Access to
15 Insurance Requirements) Plan under Article 21.49A; or

16 (4) other recommendations the executive committee
17 considers appropriate. (V.T.I.C. Art. 21.49-12, Sec. 6(b) (part).)

18 Sec. 523.203. TERMINATION OF PROGRAM. The department may
19 terminate the market assistance program only on the commissioner's
20 approval. (V.T.I.C. Art. 21.49-12, Sec. 6(b) (part).)

21 [Chapters 524-540 reserved for expansion]

22 SUBTITLE C. DECEPTIVE, UNFAIR, AND PROHIBITED PRACTICES

23 CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR

24 DECEPTIVE ACTS OR PRACTICES

25 SUBCHAPTER A. GENERAL PROVISIONS

26 Sec. 541.001. PURPOSE

27 Sec. 541.002. DEFINITIONS

1 Sec. 541.003. UNFAIR METHODS OF COMPETITION AND UNFAIR OR
2 DECEPTIVE ACTS OR PRACTICES PROHIBITED
3 Sec. 541.004. VENUE FOR ACTIONS INVOLVING DEPARTMENT OR
4 COMMISSIONER
5 Sec. 541.005. APPLICABILITY TO RISK RETENTION OR PURCHASING
6 GROUP
7 Sec. 541.006. PROHIBITED CONTENT OF CERTAIN INSURANCE
8 POLICIES
9 Sec. 541.007. IMMUNITY FROM PROSECUTION
10 Sec. 541.008. LIBERAL CONSTRUCTION
11 [Sections 541.009-541.050 reserved for expansion]
12 SUBCHAPTER B. UNFAIR METHODS OF COMPETITION AND UNFAIR
13 OR DECEPTIVE ACTS OR PRACTICES DEFINED
14 Sec. 541.051. MISREPRESENTATION REGARDING POLICY OR
15 INSURER
16 Sec. 541.052. FALSE INFORMATION AND ADVERTISING
17 Sec. 541.053. DEFAMATION OF INSURER
18 Sec. 541.054. BOYCOTT, COERCION, OR INTIMIDATION
19 Sec. 541.055. FALSE FINANCIAL STATEMENT
20 Sec. 541.056. PROHIBITED REBATES AND INDUCEMENTS
21 Sec. 541.057. UNFAIR DISCRIMINATION IN LIFE INSURANCE
22 AND ANNUITY CONTRACTS
23 Sec. 541.058. CERTAIN PRACTICES NOT CONSIDERED
24 DISCRIMINATION OR INDUCEMENT
25 Sec. 541.059. DECEPTIVE NAME, WORD, SYMBOL, DEVICE, OR
26 SLOGAN
27 Sec. 541.060. UNFAIR SETTLEMENT PRACTICES

1 Sec. 541.061. MISREPRESENTATION OF INSURANCE POLICY

2 [Sections 541.062-541.100 reserved for expansion]

3 SUBCHAPTER C. DETERMINATION OF UNFAIR METHODS OF

4 COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR

5 PRACTICES; SANCTIONS AND PENALTIES

6 Sec. 541.101. EXAMINATION AND INVESTIGATION

7 Sec. 541.102. STATEMENT OF CHARGES; NOTICE OF HEARING

8 Sec. 541.103. HEARING

9 Sec. 541.104. HEARING PROCEDURES

10 Sec. 541.105. RECORD OF HEARING

11 Sec. 541.106. COMPLIANCE WITH SUBPOENA

12 Sec. 541.107. DETERMINATION OF VIOLATION

13 Sec. 541.108. CEASE AND DESIST ORDER

14 Sec. 541.109. MODIFICATION OR SETTING ASIDE OF ORDER

15 Sec. 541.110. ADMINISTRATIVE PENALTY

16 Sec. 541.111. CIVIL PENALTY FOR VIOLATION OF CEASE AND

17 DESIST ORDER

18 [Sections 541.112-541.150 reserved for expansion]

19 SUBCHAPTER D. PRIVATE ACTION FOR DAMAGES

20 Sec. 541.151. PRIVATE ACTION FOR DAMAGES AUTHORIZED

21 Sec. 541.152. DAMAGES, ATTORNEY'S FEES, AND OTHER

22 RELIEF

23 Sec. 541.153. FRIVOLOUS ACTION

24 Sec. 541.154. PRIOR NOTICE OF ACTION

25 Sec. 541.155. ABATEMENT

26 Sec. 541.156. SETTLEMENT OFFER

27 Sec. 541.157. CONTENTS OF SETTLEMENT OFFER

1 Sec. 541.158. REJECTION OF SETTLEMENT OFFER

2 Sec. 541.159. LIMIT ON RECOVERY AFTER SETTLEMENT OFFER

3 Sec. 541.160. EFFECT OF SETTLEMENT OFFER

4 Sec. 541.161. MEDIATION

5 Sec. 541.162. LIMITATIONS PERIOD

6 [Sections 541.163-541.200 reserved for expansion]

7 SUBCHAPTER E. ENFORCEMENT BY ATTORNEY GENERAL

8 Sec. 541.201. INJUNCTIVE RELIEF

9 Sec. 541.202. VENUE FOR INJUNCTIVE ACTION

10 Sec. 541.203. ISSUANCE OF INJUNCTION

11 Sec. 541.204. CIVIL PENALTY

12 Sec. 541.205. COMPENSATION OR RESTORATION

13 Sec. 541.206. CIVIL PENALTY FOR VIOLATION OF INJUNCTION

14 Sec. 541.207. REMEDIES NOT EXCLUSIVE

15 [Sections 541.208-541.250 reserved for expansion]

16 SUBCHAPTER F. CLASS ACTIONS BY ATTORNEY GENERAL OR

17 PRIVATE INDIVIDUAL

18 Sec. 541.251. CLASS ACTION AUTHORIZED

19 Sec. 541.252. RECOVERY

20 Sec. 541.253. FRIVOLOUS ACTION

21 Sec. 541.254. STATUTE OF LIMITATIONS TOLLED

22 Sec. 541.255. PRIOR NOTICE

23 Sec. 541.256. PREREQUISITES TO CLASS ACTION

24 Sec. 541.257. CLASS ACTIONS MAINTAINABLE

25 Sec. 541.258. CLASS ACTIONS: ISSUES AND SUBCLASSES

26 AUTHORIZED

27 Sec. 541.259. DETERMINATION REGARDING WHETHER CLASS

ACTION MAY BE MAINTAINED

Sec. 541.260. EFFECT OF DENIAL OF CLASS ACTION

Sec. 541.261. NOTICE OF CLASS ACTION

Sec. 541.262. PROCEDURES IN CLASS ACTION

Sec. 541.263. EFFECT OF SETTLEMENT OFFER

Sec. 541.264. DEFENSES

Sec. 541.265. LIMITATIONS PERIOD FOR DAMAGES

Sec. 541.266. DISPOSITION

Sec. 541.267. CONTENTS OF JUDGMENT; NOTICE

[Sections 541.268-541.300 reserved for expansion]

SUBCHAPTER G. DEPARTMENT ACTION FOR REFUND OF PREMIUMS

Sec. 541.301. REFUND OF PREMIUMS

Sec. 541.302. TIME TO MAKE REFUNDS

Sec. 541.303. SANCTION

Sec. 541.304. EVIDENTIARY USE OF COMPLIANCE OR ATTEMPT

TO COMPLY

[Sections 541.305-541.350 reserved for expansion]

SUBCHAPTER H. ASSURANCE OF VOLUNTARY COMPLIANCE

Sec. 541.351. ACCEPTANCE OF ASSURANCE

Sec. 541.352. EFFECT OF ASSURANCE

Sec. 541.353. REOPENING

Sec. 541.354. RIGHT TO BRING ACTION NOT AFFECTED

[Sections 541.355-541.400 reserved for expansion]

SUBCHAPTER I. RULEMAKING

Sec. 541.401. RULEMAKING AUTHORITY

Sec. 541.402. PETITION

Sec. 541.403. DENIAL OF PETITION

1 Sec. 541.404. HEARING ON PETITION

2 Sec. 541.405. JUDICIAL REVIEW OF DEPARTMENT ACTION

3 [Sections 541.406-541.450 reserved for expansion]

4 SUBCHAPTER J. CONSTRUCTION OF CHAPTER WITH OTHER LAWS

5 Sec. 541.451. LIABILITY UNDER OTHER LAW

6 Sec. 541.452. POWERS IN ADDITION TO OTHER POWERS

7 AUTHORIZED BY LAW

8 Sec. 541.453. DOUBLE RECOVERY PROHIBITED

9 Sec. 541.454. PENALTIES AND RELATED PAYMENTS BY

10 INSURER

11 CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR

12 DECEPTIVE ACTS OR PRACTICES

13 SUBCHAPTER A. GENERAL PROVISIONS

14 Sec. 541.001. PURPOSE. The purpose of this chapter is to
15 regulate trade practices in the business of insurance by:

16 (1) defining or providing for the determination of
17 trade practices in this state that are unfair methods of
18 competition or unfair or deceptive acts or practices; and

19 (2) prohibiting those trade practices. (V.T.I.C. Art.
20 21.21, Sec. 1(a).)

21 Sec. 541.002. DEFINITIONS. In this chapter:

22 (1) "Knowingly" means actual awareness of the falsity,
23 unfairness, or deceptiveness of the act or practice on which a claim
24 for damages under Subchapter D is based. Actual awareness may be
25 inferred if objective manifestations indicate that a person acted
26 with actual awareness.

27 (2) "Person" means an individual, corporation,

1 association, partnership, reciprocal or interinsurance exchange,
2 Lloyd's plan, fraternal benefit society, or other legal entity
3 engaged in the business of insurance, including an agent, broker,
4 adjuster, or life and health insurance counselor. (V.T.I.C. Art.
5 21.21, Secs. 2(a), (c).)

6 Sec. 541.003. UNFAIR METHODS OF COMPETITION AND UNFAIR OR
7 DECEPTIVE ACTS OR PRACTICES PROHIBITED. A person may not engage in
8 this state in a trade practice that is defined in this chapter as or
9 determined under this chapter to be an unfair method of competition
10 or an unfair or deceptive act or practice in the business of
11 insurance. (V.T.I.C. Art. 21.21, Sec. 3.)

12 Sec. 541.004. VENUE FOR ACTIONS INVOLVING DEPARTMENT OR
13 COMMISSIONER. An action under this chapter in which the department
14 or commissioner is a party must be brought in a district court in
15 Travis County. (V.T.I.C. Art. 21.21, Sec. 21.)

16 Sec. 541.005. APPLICABILITY TO RISK RETENTION OR PURCHASING
17 GROUP. (a) A risk retention group or purchasing group, as those
18 terms are defined by Section 2, Article 21.54, not chartered in this
19 state may not engage in a trade practice in this state that is
20 defined as unlawful under this chapter.

21 (b) A risk retention group or purchasing group is subject to
22 this chapter and rules adopted under this chapter. (V.T.I.C. Art.
23 21.21B.)

24 Sec. 541.006. PROHIBITED CONTENT OF CERTAIN INSURANCE
25 POLICIES. Notwithstanding any other provision of this code, it is
26 unlawful for an insurer engaged in the business of life, accident,
27 or health insurance to issue or deliver in this state a policy

1 containing the words "Approved by the Texas Department of
2 Insurance" or words of a similar meaning. (V.T.I.C. Art. 21.21,
3 Sec. 9(a).)

4 Sec. 541.007. IMMUNITY FROM PROSECUTION. (a) This section
5 applies to a person who requests to be excused from attending and
6 testifying at a hearing or from producing books, papers, records,
7 correspondence, or other documents at the hearing on the ground
8 that the testimony or evidence may:

9 (1) tend to incriminate the person; or

10 (2) subject the person to a penalty or forfeiture.

11 (b) A person who, notwithstanding a request described by
12 Subsection (a), is directed to provide the testimony or produce the
13 documents shall comply with that direction. Except as provided by
14 Subsection (c), the person may not be prosecuted or subjected to a
15 penalty or forfeiture for or on account of a transaction, matter, or
16 thing about which the person testifies or produces documents, and
17 the testimony or documents produced may not be received against the
18 person in a criminal action, investigation, or proceeding.

19 (c) A person who complies with a direction to testify or
20 produce documents is not exempt from prosecution or punishment for
21 perjury committed while testifying and the testimony or evidence
22 given or produced is admissible against the person in a criminal
23 action, investigation, or proceeding concerning the perjury, and
24 the person is not exempt from the denial, revocation, or suspension
25 of any license, permission, or authority conferred or to be
26 conferred under this code.

27 (d) A person may waive the immunity or privilege granted by

1 this section by executing, acknowledging, and filing with the
2 department a statement expressly waiving the immunity or privilege
3 for a specified transaction, matter, or thing. On filing the
4 statement:

5 (1) the testimony or documents produced by the person
6 in relation to the transaction, matter, or thing may be received by
7 or produced before a judge or justice or a court, grand jury, or
8 other tribunal; and

9 (2) the person is not entitled to immunity or
10 privilege for the testimony or documents received or produced under
11 Subdivision (1). (V.T.I.C. Art. 21.21, Sec. 12.)

12 Sec. 541.008. LIBERAL CONSTRUCTION. This chapter shall be
13 liberally construed and applied to promote the underlying purposes
14 as provided by Section 541.001. (V.T.I.C. Art. 21.21, Sec. 1(b).)

15 [Sections 541.009-541.050 reserved for expansion]

16 SUBCHAPTER B. UNFAIR METHODS OF COMPETITION AND UNFAIR

17 OR DECEPTIVE ACTS OR PRACTICES DEFINED

18 Sec. 541.051. MISREPRESENTATION REGARDING POLICY OR
19 INSURER. It is an unfair method of competition or an unfair or
20 deceptive act or practice in the business of insurance to:

21 (1) make, issue, or circulate or cause to be made,
22 issued, or circulated an estimate, illustration, circular, or
23 statement misrepresenting with respect to a policy issued or to be
24 issued:

25 (A) the terms of the policy;

26 (B) the benefits or advantages promised by the
27 policy; or

1 (C) the dividends or share of surplus to be
2 received on the policy;

3 (2) make a false or misleading statement regarding the
4 dividends or share of surplus previously paid on a similar policy;

5 (3) make a misleading representation or
6 misrepresentation regarding:

7 (A) the financial condition of an insurer; or

8 (B) the legal reserve system on which a life
9 insurer operates;

10 (4) use a name or title of a policy or class of
11 policies that misrepresents the true nature of the policy or class
12 of policies; or

13 (5) make a misrepresentation to a policyholder insured
14 by any insurer for the purpose of inducing or that tends to induce
15 the policyholder to allow an existing policy to lapse or to forfeit
16 or surrender the policy. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

17 Sec. 541.052. FALSE INFORMATION AND ADVERTISING. (a) It is
18 an unfair method of competition or an unfair or deceptive act or
19 practice in the business of insurance to make, publish,
20 disseminate, circulate, or place before the public or directly or
21 indirectly cause to be made, published, disseminated, circulated,
22 or placed before the public an advertisement, announcement, or
23 statement containing an untrue, deceptive, or misleading
24 assertion, representation, or statement regarding the business of
25 insurance or a person in the conduct of the person's insurance
26 business.

27 (b) This section applies to an advertisement, announcement,

1 or statement made, published, disseminated, circulated, or placed
2 before the public:

- 3 (1) in a newspaper, magazine, or other publication;
- 4 (2) in a notice, circular, pamphlet, letter, or
5 poster;
- 6 (3) over a radio or television station; or
- 7 (4) in any other manner. (V.T.I.C. Art. 21.21, Sec. 4
8 (part).)

9 Sec. 541.053. DEFAMATION OF INSURER. (a) It is an unfair
10 method of competition or an unfair or deceptive act or practice in
11 the business of insurance to directly or indirectly make, publish,
12 disseminate, or circulate or to aid, abet, or encourage the making,
13 publication, dissemination, or circulation of a statement that:

- 14 (1) is false, maliciously critical of, or derogatory
15 to the financial condition of an insurer; and
- 16 (2) is calculated to injure a person engaged in the
17 business of insurance.

18 (b) This section applies to any oral or written statement,
19 including a statement in any pamphlet, circular, article, or
20 literature. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

21 Sec. 541.054. BOYCOTT, COERCION, OR INTIMIDATION. It is an
22 unfair method of competition or an unfair or deceptive act or
23 practice in the business of insurance to commit through concerted
24 action or to enter into an agreement to commit an act of boycott,
25 coercion, or intimidation that results in or tends to result in the
26 unreasonable restraint of or a monopoly in the business of
27 insurance. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

1 Sec. 541.055. FALSE FINANCIAL STATEMENT. (a) It is an
2 unfair method of competition or an unfair or deceptive act or
3 practice in the business of insurance to, with intent to deceive:

4 (1) file with a supervisory or other public official a
5 false statement of financial condition of an insurer; or

6 (2) make, publish, disseminate, circulate, deliver to
7 any person, or place before the public or directly or indirectly
8 cause to be made, published, disseminated, circulated, delivered to
9 any person, or placed before the public a false statement of
10 financial condition of an insurer.

11 (b) It is an unfair method of competition or an unfair or
12 deceptive act or practice in the business of insurance to make a
13 false entry in an insurer's book, report, or statement or wilfully
14 omit to make a true entry of a material fact relating to the
15 insurer's business in the insurer's book, report, or statement with
16 intent to deceive:

17 (1) an agent or examiner lawfully appointed to examine
18 the insurer's condition or affairs; or

19 (2) a public official to whom the insurer is required
20 by law to report or who has authority by law to examine the
21 insurer's condition or affairs. (V.T.I.C. Art. 21.21, Sec. 4
22 (part).)

23 Sec. 541.056. PROHIBITED REBATES AND INDUCEMENTS. (a)
24 Subject to Section 541.058 and except as otherwise expressly
25 provided by law, it is an unfair method of competition or an unfair
26 or deceptive act or practice in the business of insurance to
27 knowingly permit the making of, offer to make, or make a life

1 insurance contract, life annuity contract, or accident and health
2 insurance contract or an agreement regarding the contract, other
3 than as plainly expressed in the issued contract, or directly or
4 indirectly pay, give, or allow or offer to pay, give, or allow as
5 inducement to enter into a life insurance contract, life annuity
6 contract, or accident and health insurance contract a rebate of
7 premiums payable on the contract, a special favor or advantage in
8 the dividends or other benefits of the contract, or a valuable
9 consideration or inducement not specified in the contract, or give,
10 sell, or purchase or offer to give, sell, or purchase in connection
11 with a life insurance, life annuity, or accident and health
12 insurance contract or as inducement to enter into the contract
13 stocks, bonds, or other securities of an insurer or other
14 corporation, association, or partnership, dividends or profits
15 accrued from the stocks, bonds, or securities, or anything of value
16 not specified in the contract.

17 (b) It is an unfair method of competition or an unfair or
18 deceptive act or practice in the business of insurance to issue or
19 deliver or to permit an agent, officer, or employee to issue or
20 deliver as an inducement to insurance:

- 21 (1) company stock or other capital stock;
22 (2) a benefit certificate or share in a corporation;
23 (3) securities; or
24 (4) a special or advisory board contract or any other
25 contract promising returns or profits.

26 (c) Subsection (b) does not prohibit issuing or delivering a
27 participating insurance policy otherwise authorized by law.

1 (V.T.I.C. Art. 21.21, Sec. 4 (part).)

2 Sec. 541.057. UNFAIR DISCRIMINATION IN LIFE INSURANCE AND
3 ANNUITY CONTRACTS. Subject to Section 541.058, it is an unfair
4 method of competition or an unfair or deceptive act or practice in
5 the business of insurance to make or permit with respect to a life
6 insurance or life annuity contract an unfair discrimination between
7 individuals of the same class and equal life expectancy regarding:

8 (1) the rates charged;

9 (2) the dividends or other benefits payable; or

10 (3) any of the other terms and conditions of the
11 contract. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

12 Sec. 541.058. CERTAIN PRACTICES NOT CONSIDERED
13 DISCRIMINATION OR INDUCEMENT. It is not a rebate or discrimination
14 prohibited by Section 541.056(a) or 541.057:

15 (1) for a life insurance or life annuity contract, to
16 pay a bonus to a policyholder or otherwise abate the policyholder's
17 premiums in whole or in part out of surplus accumulated from
18 nonparticipating insurance policies if the bonus or abatement:

19 (A) is fair and equitable to policyholders; and

20 (B) is in the best interests of the insurer and
21 its policyholders;

22 (2) for a life insurance policy issued on the
23 industrial debit plan, to make to a policyholder who has
24 continuously for a specified period made premium payments directly
25 to the insurer's office an allowance in an amount that fairly
26 represents the saving in collection expenses;

27 (3) for a group insurance policy, to readjust the rate

1 of premium based on the loss or expense experience under the policy
2 at the end of a policy year if the adjustment is retroactive for
3 only that policy year; or

4 (4) for a life annuity contract, to waive surrender
5 charges under the contract when the contract holder exchanges that
6 contract for another annuity contract issued by the same insurer if
7 the waiver and the exchange are fully, fairly, and accurately
8 explained to the contract holder in a manner that is not deceptive
9 or misleading. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

10 Sec. 541.059. DECEPTIVE NAME, WORD, SYMBOL, DEVICE, OR
11 SLOGAN. (a) Except as provided by Subsection (b), it is an unfair
12 method of competition or an unfair or deceptive act or practice in
13 the business of insurance to use, display, publish, circulate,
14 distribute, or cause to be used, displayed, published, circulated,
15 or distributed in a letter, pamphlet, circular, contract, policy,
16 evidence of coverage, article, poster, or other document,
17 literature, or public media:

18 (1) a name as the corporate or business name of a
19 person or entity engaged in the business of insurance or in an
20 insurance-related business in this state that is the same as or
21 deceptively similar to the name adopted and used by an insurance
22 entity, health maintenance organization, third-party
23 administrator, or group hospital service corporation authorized to
24 engage in business under the laws of this state; or

25 (2) a word, symbol, device, or slogan, either alone or
26 in combination and regardless of whether registered, and including
27 the titles, designations, character names, and distinctive

1 features of broadcast or other advertising, that is the same as or
2 deceptively similar to a word, symbol, device, or slogan adopted
3 and used by an insurance entity, health maintenance organization,
4 third-party administrator, or group hospital service corporation
5 to distinguish the entity or the entity's products or services from
6 another entity.

7 (b) If more than one person or entity uses names, words,
8 symbols, devices, or slogans, either alone or in combination, that
9 are the same or deceptively similar and are likely to cause
10 confusion or mistake, the person or entity that demonstrates the
11 first continuous actual use of the name, word, symbol, device,
12 slogan, or combination has not engaged in an unfair method of
13 competition or deceptive act or practice under this section.
14 (V.T.I.C. Art. 21.21, Sec. 4 (part).)

15 Sec. 541.060. UNFAIR SETTLEMENT PRACTICES. (a) It is an
16 unfair method of competition or an unfair or deceptive act or
17 practice in the business of insurance to engage in the following
18 unfair settlement practices with respect to a claim by an insured or
19 beneficiary:

20 (1) misrepresenting to a claimant a material fact or
21 policy provision relating to coverage at issue;

22 (2) failing to attempt in good faith to effectuate a
23 prompt, fair, and equitable settlement of:

24 (A) a claim with respect to which the insurer's
25 liability has become reasonably clear; or

26 (B) a claim under one portion of a policy with
27 respect to which the insurer's liability has become reasonably

1 clear to influence the claimant to settle another claim under
2 another portion of the coverage unless payment under one portion of
3 the coverage constitutes evidence of liability under another
4 portion;

5 (3) failing to promptly provide to a policyholder a
6 reasonable explanation of the basis in the policy, in relation to
7 the facts or applicable law, for the insurer's denial of a claim or
8 offer of a compromise settlement of a claim;

9 (4) failing within a reasonable time to:

10 (A) affirm or deny coverage of a claim to a
11 policyholder; or

12 (B) submit a reservation of rights to a
13 policyholder;

14 (5) refusing, failing, or unreasonably delaying a
15 settlement offer under applicable first-party coverage on the basis
16 that other coverage may be available or that third parties are
17 responsible for the damages suffered, except as may be specifically
18 provided in the policy;

19 (6) undertaking to enforce a full and final release of
20 a claim from a policyholder when only a partial payment has been
21 made, unless the payment is a compromise settlement of a doubtful or
22 disputed claim;

23 (7) refusing to pay a claim without conducting a
24 reasonable investigation with respect to the claim;

25 (8) with respect to a Texas personal automobile
26 insurance policy, delaying or refusing settlement of a claim solely
27 because there is other insurance of a different kind available to

1 satisfy all or part of the loss forming the basis of that claim; or

2 (9) requiring a claimant as a condition of settling a
3 claim to produce the claimant's federal income tax returns for
4 examination or investigation by the person unless:

5 (A) a court orders the claimant to produce those
6 tax returns;

7 (B) the claim involves a fire loss; or

8 (C) the claim involves lost profits or income.

9 (b) Subsection (a) does not provide a cause of action to a
10 third party asserting one or more claims against an insured covered
11 under a liability insurance policy. (V.T.I.C. Art. 21.21, Sec. 4
12 (part).)

13 Sec. 541.061. MISREPRESENTATION OF INSURANCE POLICY. It is
14 an unfair method of competition or an unfair or deceptive act or
15 practice in the business of insurance to misrepresent an insurance
16 policy by:

17 (1) making an untrue statement of material fact;

18 (2) failing to state a material fact necessary to make
19 other statements made not misleading, considering the
20 circumstances under which the statements were made;

21 (3) making a statement in a manner that would mislead a
22 reasonably prudent person to a false conclusion of a material fact;

23 (4) making a material misstatement of law; or

24 (5) failing to disclose a matter required by law to be
25 disclosed, including failing to make a disclosure in accordance
26 with another provision of this code. (V.T.I.C. Art. 21.21, Sec. 4
27 (part).)

[Sections 541.062-541.100 reserved for expansion]

SUBCHAPTER C. DETERMINATION OF UNFAIR METHODS OF COMPETITION
AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES;
SANCTIONS AND PENALTIES

Sec. 541.101. EXAMINATION AND INVESTIGATION. The department may examine and investigate the affairs of a person engaged in the business of insurance in this state to determine whether the person has or is engaged in an unfair method of competition or unfair or deceptive act or practice prohibited by Section 541.003. (V.T.I.C. Art. 21.21, Sec. 5.)

Sec. 541.102. STATEMENT OF CHARGES; NOTICE OF HEARING. (a) When the department has reason to believe that a person engaged in the business of insurance in this state has engaged or is engaging in this state in an unfair method of competition or unfair or deceptive act or practice defined by Subchapter B and that a proceeding by the department regarding the charges is in the interest of the public, the department shall issue and serve on the person:

- (1) a statement of the charges; and
- (2) a notice of the hearing on the charges, including the time and place for the hearing.

(b) The department may not hold the hearing before the sixth day after the date the notice is served. (V.T.I.C. Art. 21.21, Sec. 6(a).)

Sec. 541.103. HEARING. A person against whom charges are made under Section 541.102 is entitled at the hearing on the charges to have an opportunity to be heard and show cause why the department

1 should not issue an order requiring the person to cease and desist
2 from the unfair method of competition or unfair or deceptive act or
3 practice described in the charges. (V.T.I.C. Art. 21.21, Sec. 6(b)
4 (part).)

5 Sec. 541.104. HEARING PROCEDURES. (a) Nothing in this
6 chapter requires the observance of formal rules of pleading or
7 evidence at a hearing under this subchapter.

8 (b) At a hearing under this subchapter, the department, on a
9 showing of good cause, shall permit any person to intervene,
10 appear, and be heard by counsel or in person. (V.T.I.C. Art. 21.21,
11 Secs. 6(b) (part), (c).)

12 Sec. 541.105. RECORD OF HEARING. (a) At a hearing under
13 this subchapter, the department may, and at the request of a party
14 to the hearing shall, make a stenographic record of the proceedings
15 and the evidence presented at the hearing.

16 (b) If the department does not make a stenographic record
17 and a person seeks judicial review of the decision made at the
18 hearing, the department shall prepare a statement of the evidence
19 and proceeding for use on review. (V.T.I.C. Art. 21.21, Sec. 6(d)
20 (part).)

21 Sec. 541.106. COMPLIANCE WITH SUBPOENA. (a) If a person
22 refuses to comply with a subpoena issued in connection with a
23 hearing under this subchapter or refuses to testify with respect to
24 a matter about which the person may be lawfully interrogated, on
25 application of the department, a district court in Travis County or
26 in the county in which the person resides may order the person to
27 comply with the subpoena or testify.

1 (b) A court may punish as contempt a person's failure to
2 obey an order under this section. (V.T.I.C. Art. 21.21, Sec. 6(d)
3 (part).)

4 Sec. 541.107. DETERMINATION OF VIOLATION. After a hearing
5 under this subchapter, the department shall determine whether:

6 (1) the method of competition or the act or practice
7 considered in the hearing is defined as:

8 (A) an unfair method of competition or deceptive
9 act or practice under Subchapter B or a rule adopted under this
10 chapter; or

11 (B) a false, misleading, or deceptive act or
12 practice under Section 17.46, Business & Commerce Code; and

13 (2) the person against whom the charges were made
14 engaged in the method of competition or act or practice in violation
15 of:

16 (A) this chapter or a rule adopted under this
17 chapter; or

18 (B) Subchapter E, Chapter 17, Business & Commerce
19 Code, as specified in Section 17.46, Business & Commerce Code.
20 (V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

21 Sec. 541.108. CEASE AND DESIST ORDER. On determining that a
22 person committed a violation described by Section 541.107, the
23 department shall:

24 (1) make written findings; and

25 (2) issue and serve on the person an order requiring
26 the person to cease and desist from engaging in the method of
27 competition or act or practice determined to be a violation.

1 (V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

2 Sec. 541.109. MODIFICATION OR SETTING ASIDE OF ORDER. On
3 the notice and in the manner the department determines proper, the
4 department may modify or set aside in whole or in part a cease and
5 desist order issued under Section 541.108 at any time before a
6 petition appealing the order is filed in accordance with Subchapter
7 D, Chapter 36. (V.T.I.C. Art. 21.21, Sec. 7(b).)

8 Sec. 541.110. ADMINISTRATIVE PENALTY. (a) A person who
9 violates a cease and desist order issued under Section 541.108 is
10 subject to an administrative penalty under Chapter 84.

11 (b) In determining whether a person has violated a cease and
12 desist order, the department shall consider the maintenance of
13 procedures reasonably adapted to ensure compliance with the order.

14 (c) An administrative penalty imposed under this section
15 may not exceed:

16 (1) \$1,000 for each violation; or

17 (2) \$5,000 for all violations.

18 (d) An order of the department imposing an administrative
19 penalty under this section applies only to a violation of the cease
20 and desist order committed before the date the order imposing the
21 penalty is issued. (V.T.I.C. Art. 21.21, Secs. 7(c), (d).)

22 Sec. 541.111. CIVIL PENALTY FOR VIOLATION OF CEASE AND
23 DESIST ORDER. (a) A person who is found by a court to have violated
24 a cease and desist order issued under Section 541.108 is liable to
25 the state for a penalty. The state may recover the penalty in a
26 civil action.

27 (b) The penalty may not exceed \$50 unless the court finds

1 the violation to be wilful, in which case the penalty may not exceed
2 \$500. (V.T.I.C. Art. 21.21, Sec. 10.)

3 [Sections 541.112-541.150 reserved for expansion]

4 SUBCHAPTER D. PRIVATE ACTION FOR DAMAGES

5 Sec. 541.151. PRIVATE ACTION FOR DAMAGES AUTHORIZED. A
6 person who sustains actual damages may bring an action against
7 another person for those damages caused by the other person
8 engaging in an act or practice:

9 (1) defined by Subchapter B to be an unfair method of
10 competition or an unfair or deceptive act or practice in the
11 business of insurance; or

12 (2) specifically enumerated in Section 17.46(b),
13 Business & Commerce Code, as an unlawful deceptive trade practice
14 if the person bringing the action shows that the person relied on
15 the act or practice to the person's detriment. (V.T.I.C. Art.
16 21.21, Sec. 16(a).)

17 Sec. 541.152. DAMAGES, ATTORNEY'S FEES, AND OTHER RELIEF.

18 (a) A plaintiff who prevails in an action under this subchapter may
19 obtain:

20 (1) the amount of actual damages, plus court costs and
21 reasonable and necessary attorney's fees;

22 (2) an order enjoining the act or failure to act
23 complained of; or

24 (3) any other relief the court determines is proper.

25 (b) On a finding by the trier of fact that the defendant
26 knowingly committed the act complained of, the trier of fact may
27 award an amount not to exceed three times the amount of actual

1 damages. (V.T.I.C. Art. 21.21, Sec. 16(b).)

2 Sec. 541.153. FRIVOLOUS ACTION. A court shall award to the
3 defendant court costs and reasonable and necessary attorney's fees
4 if the court finds that an action under this subchapter is
5 groundless and brought in bad faith or brought for the purpose of
6 harassment. (V.T.I.C. Art. 21.21, Sec. 16(c).)

7 Sec. 541.154. PRIOR NOTICE OF ACTION. (a) A person seeking
8 damages in an action against another person under this subchapter
9 must provide written notice to the other person not later than the
10 61st day before the date the action is filed.

11 (b) The notice must advise the other person of:

12 (1) the specific complaint; and

13 (2) the amount of actual damages and expenses,
14 including attorney's fees reasonably incurred in asserting the
15 claim against the other person.

16 (c) The notice is not required if giving notice is
17 impracticable because the action:

18 (1) must be filed to prevent the statute of
19 limitations from expiring; or

20 (2) is asserted as a counterclaim. (V.T.I.C. Art.
21 21.21, Secs. 16(e), (f).)

22 Sec. 541.155. ABATEMENT. (a) A person against whom an
23 action under this subchapter is pending who does not receive the
24 notice as required by Section 541.154 may file a plea in abatement
25 not later than the 30th day after the date the person files an
26 original answer in the court in which the action is pending.

27 (b) The court shall abate the action if, after a hearing,

1 the court finds that the person is entitled to an abatement because
2 the claimant did not provide the notice as required by Section
3 541.154.

4 (c) An action is automatically abated without a court order
5 beginning on the 11th day after the date a plea in abatement is
6 filed if the plea:

7 (1) is verified and alleges that the person against
8 whom the action is pending did not receive the notice as required by
9 Section 541.154; and

10 (2) is not controverted by an affidavit filed by the
11 claimant before the 11th day after the date the plea in abatement is
12 filed.

13 (d) An abatement under this section continues until the 60th
14 day after the date notice is provided in compliance with Section
15 541.154.

16 (e) This section does not apply if Section 541.154(c)
17 applies. (V.T.I.C. Art. 21.21, Secs. 16(g), (h), (i).)

18 Sec. 541.156. SETTLEMENT OFFER. (a) A person who receives
19 notice provided under Section 541.154 may make a settlement offer
20 during a period beginning on the date notice under Section 541.154
21 is received and ending on the 60th day after that date.

22 (b) In addition to the period described by Subsection (a),
23 the person may make a settlement offer during a period:

24 (1) if mediation is not conducted under Section
25 541.161, beginning on the date an original answer is filed in the
26 action and ending on the 90th day after that date; or

27 (2) if mediation is conducted under Section 541.161,

1 beginning on the day after the date the mediation ends and ending on
2 the 20th day after that date. (V.T.I.C. Art. 21.21, Secs. 16A(a),
3 (b), (c).)

4 Sec. 541.157. CONTENTS OF SETTLEMENT OFFER. A settlement
5 offer made by a person against whom a claim under this subchapter is
6 pending must include an offer to pay the following amounts,
7 separately stated:

8 (1) an amount of money or other consideration, reduced
9 to its cash value, as settlement of the claim for damages; and

10 (2) an amount of money to compensate the claimant for
11 the claimant's reasonable and necessary attorney's fees incurred as
12 of the date of the offer. (V.T.I.C. Art. 21.21, Sec. 16A(d).)

13 Sec. 541.158. REJECTION OF SETTLEMENT OFFER. (a) A
14 settlement offer is rejected unless both parts of the offer
15 required under Section 541.157 are accepted by the claimant not
16 later than the 30th day after the date the offer is made.

17 (b) A settlement offer made by a person against whom a claim
18 under this subchapter is pending that complies with this subchapter
19 and is rejected by the claimant may be filed with the court
20 accompanied by an affidavit certifying the offer's rejection.
21 (V.T.I.C. Art. 21.21, Secs. 16A(e), (f).)

22 Sec. 541.159. LIMIT ON RECOVERY AFTER SETTLEMENT OFFER.
23 (a) If the court finds that the amount stated in the settlement
24 offer for damages under Section 541.157(1) is the same as,
25 substantially the same as, or more than the amount of damages found
26 by the trier of fact, the claimant may not recover as damages any
27 amount in excess of the lesser of:

1 (1) the amount of damages stated in the offer; or

2 (2) the amount of damages found by the trier of fact.

3 (b) If the court makes the finding described by Subsection
4 (a), the court shall determine reasonable and necessary attorney's
5 fees to compensate the claimant for attorney's fees incurred before
6 the date and time the rejected settlement offer was made. If the
7 court finds that the amount stated in the offer for attorney's fees
8 under Section 541.157(2) is the same as, substantially the same as,
9 or more than the amount of reasonable and necessary attorney's fees
10 incurred by the claimant as of the date of the offer, the claimant
11 may not recover any amount of attorney's fees in excess of the
12 amount of fees stated in the offer.

13 (c) This section does not apply if the court finds that the
14 offering party:

15 (1) could not perform the offer at the time the offer
16 was made; or

17 (2) substantially misrepresented the cash value of the
18 offer.

19 (d) The court shall award:

20 (1) damages as required by Section 541.152 if
21 Subsection (a) does not apply; and

22 (2) attorney's fees as required by Section 541.152 if
23 Subsection (b) does not apply. (V.T.I.C. Art. 21.21, Secs. 16A(g),
24 (h), (i), (j).)

25 Sec. 541.160. EFFECT OF SETTLEMENT OFFER. A settlement
26 offer is not an admission of engaging in an act or practice defined
27 by Subchapter B to be an unfair method of competition or an unfair

1 or deceptive act or practice in the business of insurance.
2 (V.T.I.C. Art. 21.21, Sec. 16A(k).)

3 Sec. 541.161. MEDIATION. (a) A party may, not later than
4 the 90th day after the date a pleading seeking relief under this
5 subchapter is served, file a motion to compel mediation of the
6 dispute in the manner provided by this section.

7 (b) The court shall, not later than the 30th day after the
8 date a motion under this section is filed, sign an order setting the
9 time and place of the mediation.

10 (c) The court shall appoint a mediator if the parties do not
11 agree on a mediator.

12 (d) The mediation must be held not later than the 30th day
13 after the date the order is signed, unless:

14 (1) the parties agree otherwise; or

15 (2) the court determines that additional time not to
16 exceed 30 days is warranted.

17 (e) Each party who has appeared in the action, except as
18 agreed to by all parties who have appeared, shall:

19 (1) participate in the mediation; and

20 (2) except as provided by Subsection (f), share the
21 mediation fee.

22 (f) A party may not compel mediation under this section if
23 the amount of actual damages claimed is less than \$15,000 unless the
24 party seeking to compel mediation agrees to pay the costs of the
25 mediation.

26 (g) Except as provided by this section, the following apply
27 to the appointment of a mediator and the mediation process provided

by this section:

(1) Section 154.023, Civil Practice and Remedies Code;
and

(2) Subchapters C and D, Chapter 154, Civil Practice
and Remedies Code. (V.T.I.C. Art. 21.21, Sec. 16B.)

Sec. 541.162. LIMITATIONS PERIOD. (a) A person must bring
an action under this chapter before the second anniversary of the
following:

(1) the date the unfair method of competition or
unfair or deceptive act or practice occurred; or

(2) the date the person discovered or, by the exercise
of reasonable diligence, should have discovered that the unfair
method of competition or unfair or deceptive act or practice
occurred.

(b) The limitations period provided by Subsection (a) may be
extended for 180 days if the person bringing the action proves that
the person's failure to bring the action within that period was
caused by the defendant's engaging in conduct solely calculated to
induce the person to refrain from or postpone bringing the action.
(V.T.I.C. Art. 21.21, Sec. 16(d).)

[Sections 541.163-541.200 reserved for expansion]

SUBCHAPTER E. ENFORCEMENT BY ATTORNEY GENERAL

Sec. 541.201. INJUNCTIVE RELIEF. (a) The attorney general
may bring an action under this section if the attorney general has
reason to believe that:

(1) a person engaged in the business of insurance in
this state is engaging in, has engaged in, or is about to engage in

1 an act or practice defined as unlawful under:

2 (A) this chapter or a rule adopted under this
3 chapter; or

4 (B) Section 17.46, Business & Commerce Code; and
5 (2) the action is in the public interest.

6 (b) The attorney general may bring the action in the name of
7 the state to restrain by temporary or permanent injunction the
8 person's use of the method, act, or practice. (V.T.I.C. Art. 21.21,
9 Sec. 15(a).)

10 Sec. 541.202. VENUE FOR INJUNCTIVE ACTION. An action for an
11 injunction under this subchapter may be commenced in a district
12 court in:

13 (1) the county in which the person against whom the
14 action is brought:

15 (A) resides;
16 (B) has the person's principal place of business;
17 or

18 (C) is engaging in business;
19 (2) the county in which the transaction or a
20 substantial portion of the transaction occurred; or

21 (3) Travis County. (V.T.I.C. Art. 21.21, Sec. 15(b)
22 (part).)

23 Sec. 541.203. ISSUANCE OF INJUNCTION. (a) The court may
24 issue an appropriate temporary or permanent injunction.

25 (b) The court shall issue the injunction without bond.
26 (V.T.I.C. Art. 21.21, Sec. 15(b) (part).)

27 Sec. 541.204. CIVIL PENALTY. In addition to requesting a

1 temporary or permanent injunction under Section 541.201, the
2 attorney general may request a civil penalty of not more than
3 \$10,000 for each violation on a finding by the court that the
4 defendant has engaged in or is engaging in an act or practice
5 defined as unlawful under:

6 (1) this chapter or a rule adopted under this chapter;
7 or

8 (2) Section 17.46, Business & Commerce Code.
9 (V.T.I.C. Art. 21.21, Sec. 15(c).)

10 Sec. 541.205. COMPENSATION OR RESTORATION. The court may
11 make an additional order or judgment as necessary to compensate an
12 identifiable person for actual damages or for restoration of money
13 or property that may have been acquired by means of an enjoined act
14 or practice. (V.T.I.C. Art. 21.21, Sec. 15(d).)

15 Sec. 541.206. CIVIL PENALTY FOR VIOLATION OF INJUNCTION.
16 (a) A person who violates an injunction issued under this
17 subchapter is liable for and shall pay to the state a civil penalty
18 of not more than \$10,000 for each violation.

19 (b) The attorney general may, in the name of the state,
20 petition the court for recovery of the civil penalty against the
21 person who violates the injunction.

22 (c) The court shall consider the maintenance of procedures
23 reasonably adapted to ensure compliance with the injunction in
24 determining whether a person has violated an injunction.

25 (d) The court issuing the injunction retains jurisdiction
26 and the cause is continued for the purpose of assessing a civil
27 penalty under this section. (V.T.I.C. Art. 21.21, Sec. 15(e).)

1 Sec. 541.207. REMEDIES NOT EXCLUSIVE. The remedies
2 provided by this subchapter are:

3 (1) not exclusive; and

4 (2) in addition to any other remedy or procedure
5 provided by another law or at common law. (V.T.I.C. Art. 21.21,
6 Sec. 15(f).)

7 [Sections 541.208-541.250 reserved for expansion]

8 SUBCHAPTER F. CLASS ACTIONS BY ATTORNEY GENERAL OR
9 PRIVATE INDIVIDUAL

10 Sec. 541.251. CLASS ACTION AUTHORIZED. (a) If a member of
11 the insurance buying public has been damaged by an unlawful method,
12 act, or practice defined in Subchapter B as an unlawful deceptive
13 trade practice, the department may request the attorney general to
14 bring a class action or the individual damaged may bring an action
15 on the individual's own behalf and on behalf of others similarly
16 situated to recover damages and obtain relief as provided by this
17 subchapter.

18 (b) A class action may not be maintained under this
19 subchapter if the department and attorney general have initiated an
20 action under Subchapter G or an action under that subchapter has
21 resulted in a final determination regarding the same act or
22 practice and the same defendant in the action under this
23 subchapter. (V.T.I.C. Art. 21.21, Secs. 17(a), (e).)

24 Sec. 541.252. RECOVERY. A plaintiff who prevails in a class
25 action under this subchapter may recover:

26 (1) court costs and attorney's fees reasonable in
27 relation to the amount of work expended in addition to actual

1 damages;

2 (2) an order enjoining the act or failure to act; and

3 (3) any other relief the court determines is proper.

4 (V.T.I.C. Art. 21.21, Sec. 17(b).)

5 Sec. 541.253. FRIVOLOUS ACTION. The court may award to the
6 defendant court costs and reasonable attorney's fees in relation to
7 the work expended on a finding by the court that a class action
8 under this subchapter was brought by an individual plaintiff in bad
9 faith or for the purpose of harassment. (V.T.I.C. Art. 21.21, Sec.
10 17(c).)

11 Sec. 541.254. STATUTE OF LIMITATIONS TOLLED. The filing of
12 a class action under this subchapter tolls the statute of
13 limitations for bringing an action by an individual under Section
14 541.162. (V.T.I.C. Art. 21.21, Sec. 18(k) (part).)

15 Sec. 541.255. PRIOR NOTICE. (a) Not later than the 31st
16 day before the date a class action for damages is commenced under
17 this subchapter, the prospective plaintiff must:

18 (1) notify the intended defendant of the complaint;

19 and

20 (2) demand that the defendant provide relief to the
21 prospective plaintiff and others similarly situated.

22 (b) The notice must be in writing and be sent by certified or
23 registered mail, return receipt requested, to:

24 (1) the place where the transaction occurred;

25 (2) the intended defendant's principal place of
26 business in this state; or

27 (3) if notice to the place described by Subdivision

1 (1) or (2) does not effect notice, the office of the secretary of
2 state.

3 (c) A copy of the notice must also be sent to the
4 commissioner.

5 (d) A class action for injunctive relief may be commenced
6 under this subchapter without complying with Subsection (a).

7 (e) A plaintiff in a class action for injunctive relief
8 under this subchapter may, on or after the 31st day after the date
9 the action is commenced and after complying with Subsection (a),
10 amend the complaint without leave of court to include a request for
11 damages. (V.T.I.C. Art. 21.21, Secs. 19(a), (b), (c).)

12 Sec. 541.256. PREREQUISITES TO CLASS ACTION. The court
13 shall permit one or more members of a class to sue or be sued as
14 representative parties on behalf of the class only if:

15 (1) the class is so numerous that joinder of all
16 members is impracticable;

17 (2) there are questions of law or fact common to the
18 class;

19 (3) the claims or defenses of the representative
20 parties are typical of the claims or defenses of the class; and

21 (4) the representative parties will fairly and
22 adequately protect the interests of the class. (V.T.I.C. Art.
23 21.21, Sec. 18(a).)

24 Sec. 541.257. CLASS ACTIONS MAINTAINABLE. (a) An action
25 may be maintained as a class action under this subchapter if the
26 prerequisites of Section 541.256 are satisfied and, in addition:

27 (1) the prosecution of separate actions by or against

1 individual members of the class would create a risk of:

2 (A) inconsistent or varying adjudications with
3 respect to individual members of the class that would establish
4 incompatible standards of conduct for the party opposing the class;
5 or

6 (B) adjudication with respect to individual
7 members of the class that would as a practical matter be dispositive
8 of the interests of the other members not parties to the
9 adjudications or substantially impair or impede their ability to
10 protect their interests;

11 (2) the party opposing the class has acted or refused
12 to act on grounds generally applicable to the class, making
13 appropriate final injunctive relief or corresponding declaratory
14 relief with respect to the class as a whole; or

15 (3) the court finds that the questions of law or fact
16 common to the members of the class predominate over any questions
17 affecting only individual members and that a class action is
18 superior to other available methods for the fair and efficient
19 adjudication of the controversy.

20 (b) Matters pertinent to a finding under Subsection (a)(3)
21 include:

22 (1) the interest of members of the class in
23 individually controlling the prosecution or defense of separate
24 actions;

25 (2) the extent and nature of any litigation concerning
26 the controversy already commenced by or against members of the
27 class;

1 (3) the desirability or undesirability of
2 concentrating the litigation of the claims in the particular forum;
3 and

4 (4) the difficulties likely to be encountered in the
5 management of a class action.

6 (c) In construing this section, the courts of this state
7 shall be guided by the decisions of the federal courts interpreting
8 Rule 23, Federal Rules of Civil Procedure, as amended. (V.T.I.C.
9 Art. 21.21, Secs. 18(b), (c).)

10 Sec. 541.258. CLASS ACTIONS: ISSUES AND SUBCLASSES
11 AUTHORIZED. When appropriate, an action may be brought or
12 maintained as a class action under this subchapter with respect to
13 particular issues or a class may be divided into subclasses and each
14 subclass treated as a class, and the provisions of this subchapter
15 shall be construed and applied accordingly. (V.T.I.C. Art. 21.21,
16 Sec. 18(h).)

17 Sec. 541.259. DETERMINATION REGARDING WHETHER CLASS ACTION
18 MAY BE MAINTAINED. (a) As soon as practicable after the
19 commencement of an action brought as a class action, the court shall
20 determine by order whether it is to be maintained as a class action
21 under this subchapter.

22 (b) An order under this section may be altered or amended
23 before a decision on the merits.

24 (c) An order determining whether the action may be
25 maintained as a class action under this subchapter is an
26 interlocutory order that is appealable. The procedures applicable
27 to accelerated appeals in the Texas Rules of Appellate Procedure

1 apply to the appeal. (V.T.I.C. Art. 21.21, Sec. 18(d).)

2 Sec. 541.260. EFFECT OF DENIAL OF CLASS ACTION. A court
3 order denying that an action under this subchapter may be brought as
4 a class action does not affect whether an individual may bring the
5 same or a similar action under Subchapter D. (V.T.I.C. Art. 21.21,
6 Sec. 18(k) (part).)

7 Sec. 541.261. NOTICE OF CLASS ACTION. (a) If an action is
8 permitted as a class action under this subchapter, the court shall
9 direct to the members of the class the best notice practicable under
10 the circumstances, including individual notice to all members who
11 can be identified through reasonable effort.

12 (b) The notice must contain a statement that:

13 (1) the court will exclude from the class a notified
14 member if the member requests exclusion by a specified date;

15 (2) the judgment, whether favorable or not, includes
16 all members who do not request exclusion; and

17 (3) a member who does not request exclusion may enter
18 an appearance through counsel. (V.T.I.C. Art. 21.21, Secs. 18(e),
19 (f).)

20 Sec. 541.262. PROCEDURES IN CLASS ACTION. In a class action
21 under this subchapter, the court may make appropriate orders:

22 (1) determining the course of proceedings or
23 prescribing measures to prevent undue repetition or complication in
24 the presentation of evidence or argument;

25 (2) requiring, for the protection of the members of
26 the class or otherwise for the fair conduct of the action, that
27 notice be given in a manner the court directs to some or all of the

members or the attorney general of:

(A) any step in the action;

(B) the proposed extent of the judgment; or

(C) the opportunity for members to:

(i) signify whether the members consider the representation to be fair and adequate;

(ii) intervene and present claims or defenses; or

(iii) otherwise come into the action;

(3) imposing conditions on the representative parties or intervenors;

(4) requiring that the pleadings be amended to eliminate allegations relating to representation of absent persons, and that the action proceed accordingly; or

(5) dealing with similar procedural matters.
(V.T.I.C. Art. 21.21, Sec. 18(j).)

Sec. 541.263. EFFECT OF SETTLEMENT OFFER. (a) Damages may not be awarded to a class under this subchapter if, not later than the 30th day after the date the intended defendant receives notice under Section 541.255, the intended defendant provides to the plaintiff by certified or registered mail, return receipt requested, a written settlement offer.

(b) The settlement offer must include:

(1) a statement that all persons similarly situated have been adequately identified or a reasonable effort to identify those persons has been made;

(2) a description of the class identified and the

1 method used to identify that class;

2 (3) a statement that all persons identified have been
3 notified that, on request, the intended defendant will provide
4 relief to those persons and all others similarly situated;

5 (4) a complete explanation of the relief being
6 afforded;

7 (5) a copy of the notice or communication the intended
8 defendant is providing to the members of the class;

9 (6) a statement that the relief being afforded the
10 consumer has been or, if the offer is accepted by the consumer, will
11 be given within a stated reasonable time; and

12 (7) a statement that the practice complained of has
13 ceased.

14 (c) Except as provided by Subsection (d), an attempt to
15 comply with this section by a person receiving a demand is:

16 (1) an offer to compromise;

17 (2) not admissible as evidence; and

18 (3) not an admission of engaging in an unlawful act or
19 practice.

20 (d) A defendant may introduce evidence of compliance or an
21 attempt to comply with this section for the purpose of:

22 (1) establishing good faith; or

23 (2) showing compliance with this section. (V.T.I.C.
24 Art. 21.21, Secs. 19(d), (e).)

25 Sec. 541.264. DEFENSES. Damages may not be awarded in a
26 class action under this subchapter if the defendant:

27 (1) proves that the action complained of resulted from

1 a bona fide error, notwithstanding the use of reasonable procedures
2 adopted to avoid an error; and

3 (2) made restitution of any consideration received
4 from any member of the class. (V.T.I.C. Art. 21.21, Sec. 20.)

5 Sec. 541.265. LIMITATIONS PERIOD FOR DAMAGES. In a class
6 action under this subchapter, damages may not include any damages
7 incurred more than two years before the date the action is
8 commenced. (V.T.I.C. Art. 21.21, Sec. 17(d).)

9 Sec. 541.266. DISPOSITION. (a) A class action under this
10 subchapter may not be dismissed, settled, or compromised without
11 the approval of the court.

12 (b) Notice of the proposed dismissal, settlement, or
13 compromise shall be given to all members of the class in the manner
14 the court directs. (V.T.I.C. Art. 21.21, Sec. 18(g).)

15 Sec. 541.267. CONTENTS OF JUDGMENT; NOTICE. (a) The
16 judgment in a class action under this subchapter must describe
17 those to whom the notice under Section 541.261 was directed and who
18 have not requested exclusion and those the court finds to be members
19 of the class.

20 (b) The court shall direct to the members of the class the
21 best notice of the judgment practicable under the circumstances,
22 including individual notice to each member who can be identified
23 through reasonable effort. (V.T.I.C. Art. 21.21, Sec. 18(i).)

24 [Sections 541.268-541.300 reserved for expansion]

25 SUBCHAPTER G. DEPARTMENT ACTION FOR REFUND OF PREMIUMS

26 Sec. 541.301. REFUND OF PREMIUMS. (a) After notice and
27 hearing as provided in Subchapter C, the department may require a

1 person to make an accounting under Subsection (b):

2 (1) in connection with a method of competition or act
3 or practice that is the basis of a cease and desist order issued
4 under Section 541.108; or

5 (2) on application of an aggrieved person, in
6 connection with a determination by the department that the
7 aggrieved person and other persons similarly situated were induced
8 to purchase an insurance policy as a result of the person engaging
9 in a method of competition or act or practice in violation of:

10 (A) this chapter or a rule adopted under this
11 chapter; or

12 (B) Section 17.46, Business & Commerce Code.

13 (b) A person required to make an accounting under this
14 section must account for all premiums collected for policies issued
15 by the person during the preceding two years in connection with the
16 acts in violation of this chapter described by Subsection (a)(1) or
17 (2).

18 (c) The department may require the person described by
19 Subsection (a) to:

20 (1) give notice to all persons from whom the premiums
21 were collected; and

22 (2) refund the total of all premiums collected from
23 each person who elects to accept a premium refund in exchange for
24 cancellation of the insurance policy issued.

25 (d) A person who refunds premiums under this section shall
26 deduct from the amount of premiums refunded the amount of benefits
27 actually paid by the person while the insurance policy was in force.

1 (V.T.I.C. Art. 21.21, Sec. 14(a) (part).)

2 Sec. 541.302. TIME TO MAKE REFUNDS. The department shall
3 specify a reasonable time within which a person required to make
4 premium refunds under Section 541.301 must make the refunds.
5 (V.T.I.C. Art. 21.21, Sec. 14(a) (part).)

6 Sec. 541.303. SANCTION. (a) The department may report to
7 the attorney general a person's failure to comply with the
8 department's requirement to refund premiums within the time
9 specified under Section 541.302. The department may request that
10 the attorney general file an action to enforce the department's
11 requirement to refund premiums.

12 (b) Venue for the action is in a district court in Travis
13 County.

14 (c) The court shall enter an appropriate order to enforce
15 the department's requirement to refund premiums if the court finds
16 that:

17 (1) the requirement was lawfully entered; and

18 (2) the person failed to comply with the requirement.

19 (d) The court may enforce its order through contempt
20 proceedings.

21 (e) The sanction provided by this section is in addition to
22 any other sanctions provided in this code or other applicable laws.
23 (V.T.I.C. Art. 21.21, Sec. 14(b).)

24 Sec. 541.304. EVIDENTIARY USE OF COMPLIANCE OR ATTEMPT TO
25 COMPLY. (a) Compliance or an attempt to comply with the
26 department's requirement to refund premiums is:

27 (1) an offer to compromise;

(2) not admissible as evidence; and

(3) not an admission of engaging in an unlawful act or practice.

(b) A defendant may introduce evidence of compliance or an attempt to comply with the department's requirement for the purpose of:

(1) establishing good faith; or

(2) showing compliance with the department's requirement. (V.T.I.C. Art. 21.21, Sec. 14(c).)

[Sections 541.305-541.350 reserved for expansion]

SUBCHAPTER H. ASSURANCE OF VOLUNTARY COMPLIANCE

Sec. 541.351. ACCEPTANCE OF ASSURANCE. (a) In administering this chapter, the department may accept assurance of voluntary compliance from a person who is engaging in, has engaged in, or is about to engage in an act or practice in violation of:

(1) this chapter or a rule adopted under this chapter; or

(2) Section 17.46, Business & Commerce Code.

(b) The assurance must be in writing and be filed with the department.

(c) The department may condition acceptance of an assurance of voluntary compliance on the stipulation that the person offering the assurance restore to a person in interest money that may have been acquired by the act or practice described in Subsection (a). (V.T.I.C. Art. 21.21, Secs. 22(a), (b).)

Sec. 541.352. EFFECT OF ASSURANCE. (a) An assurance of voluntary compliance is not an admission of a prior violation of:

1 (1) this chapter or a rule adopted under this chapter;
2 or

3 (2) Section 17.46, Business & Commerce Code.

4 (b) Unless an assurance of voluntary compliance is
5 rescinded by agreement, a subsequent failure to comply with the
6 assurance is prima facie evidence of a violation of:

7 (1) this chapter or a rule adopted under this chapter;
8 or

9 (2) Section 17.46, Business & Commerce Code.
10 (V.T.I.C. Art. 21.21, Sec. 22(c).)

11 Sec. 541.353. REOPENING. A matter closed by the filing of
12 an assurance of voluntary compliance may be reopened at any time.
13 (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

14 Sec. 541.354. RIGHT TO BRING ACTION NOT AFFECTED. An
15 assurance of voluntary compliance does not affect the right of an
16 individual to bring an action under this chapter, except that the
17 right of an individual in relation to money received according to a
18 stipulation under Section 541.351(c) is governed by the terms of
19 the assurance. (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

20 [Sections 541.355-541.400 reserved for expansion]

21 SUBCHAPTER I. RULEMAKING

22 Sec. 541.401. RULEMAKING AUTHORITY. (a) The commissioner
23 may adopt and enforce reasonable rules the commissioner determines
24 necessary to accomplish the purposes of this chapter.

25 (b) Notwithstanding a previous definition or interpretation
26 of a term used in this chapter contained in or derived from the
27 common law or other statutory law of this state, the commissioner

1 may adopt an express provision necessary to accomplish the purposes
2 of this chapter, including a provision the commissioner considers
3 necessary to:

4 (1) achieve necessary uniformity with the laws of
5 other states or the United States; or

6 (2) conform to the adopted procedures of the National
7 Association of Insurance Commissioners. (V.T.I.C. Art. 21.21, Sec.
8 13(a) (part).)

9 Sec. 541.402. PETITION. (a) A petition may be submitted to
10 the commissioner to adopt, amend, or repeal a rule. The petition
11 must be:

12 (1) signed by 100 interested persons; and

13 (2) supported by evidence that:

14 (A) a particular act or practice has been or
15 could be false, misleading, or deceptive to the insurance buying
16 public; or

17 (B) an act or practice defined by department rule
18 to be false, misleading, or deceptive is not false, misleading, or
19 deceptive.

20 (b) Not later than the 30th day after the date the
21 department receives the petition, the department shall:

22 (1) deny the petition as provided by Section 541.403;

23 or

24 (2) initiate hearing proceedings under Section
25 541.404. (V.T.I.C. Art. 21.21, Sec. 13(b).)

26 Sec. 541.403. DENIAL OF PETITION. (a) The department must
27 state in writing the reason for denying a petition to adopt, amend,

1 or repeal a rule.

2 (b) The department is expressly authorized to deny the
3 petition if the action sought would:

4 (1) destroy uniformity with the laws of other states
5 or the United States; or

6 (2) not conform to the adopted procedures of the
7 National Association of Insurance Commissioners. (V.T.I.C. Art.
8 21.21, Sec. 13(c).)

9 Sec. 541.404. HEARING ON PETITION. (a) A hearing held by
10 the department in response to a petition to adopt, amend, or repeal
11 a rule must be open to the public.

12 (b) At the hearing, any person may present to the department
13 in writing or orally testimony, data, or other information
14 regarding the act or practice under consideration. (V.T.I.C. Art.
15 21.21, Sec. 13(d).)

16 Sec. 541.405. JUDICIAL REVIEW OF DEPARTMENT ACTION. (a) A
17 person aggrieved by the denial of a petition under Section 541.402
18 or the adoption, amendment, or repeal of or failure to adopt a rule
19 under this subchapter may file a petition in a district court in
20 Travis County for:

21 (1) a declaratory judgment on the validity or
22 applicability of an adopted, amended, or repealed rule; or

23 (2) review of the denial of a petition under Section
24 541.402.

25 (b) The commissioner must be made a party to the action.

26 (c) An action of the commissioner under this subchapter in
27 adopting, amending, repealing, or failing to adopt a rule or

denying a petition may be invalidated only if the court finds that the action:

(1) violates a constitutional or state statutory provision;

(2) exceeds the commissioner's statutory authority;

(3) is arbitrary or capricious or characterized by abuse of discretion or unwarranted exercise of discretion;

(4) is so vague that it does not establish sufficiently definite standards to which conduct can be conformed;

(5) is made following unlawful procedure; or

(6) is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record as submitted.

(d) The court may issue an injunction in an action under this section. (V.T.I.C. Art. 21.21, Secs. 13(e), (f).)

[Sections 541.406-541.450 reserved for expansion]

SUBCHAPTER J. CONSTRUCTION OF CHAPTER WITH OTHER LAWS

Sec. 541.451. LIABILITY UNDER OTHER LAW. An order of the department under this chapter or an order by a court to enforce that order does not relieve or absolve a person affected by either order from liability under another law of this state. (V.T.I.C. Art. 21.21, Sec. 8.)

Sec. 541.452. POWERS IN ADDITION TO OTHER POWERS AUTHORIZED BY LAW. The powers vested in the department and the commissioner by this chapter are in addition to any other powers to enforce a penalty, fine, or forfeiture authorized by law with respect to a method of competition or act or practice defined as unfair or

1 deceptive. (V.T.I.C. Art. 21.21, Sec. 11.)

2 Sec. 541.453. DOUBLE RECOVERY PROHIBITED. A person may not
3 recover damages and penalties for the same act or practice under
4 both this chapter and another law. (V.T.I.C. Art. 21.21, Sec. 11A.)

5 Sec. 541.454. PENALTIES AND RELATED PAYMENTS BY INSURER.
6 (a) Civil penalties, premium refunds, judgments, compensatory
7 judgments, individual recoveries, orders, class action awards,
8 costs, damages, or attorney's fees assessed or awarded under this
9 chapter:

10 (1) may be paid only from the capital or surplus funds
11 of the offending insurer; and

12 (2) may not take precedence over, be in priority to, or
13 in any other manner apply to:

14 (A) Article 21.28-C or 21.28-D or any other
15 insurance guaranty act; or

16 (B) Article 21.39-A.

17 (b) The statutes described by Subsection (a)(2) and the
18 priorities of funds created by those statutes are exempt from the
19 provisions of this chapter. (V.T.I.C. Art. 21.21, Sec. 23.)

20 CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

21 SUBCHAPTER A. UNFAIR CLAIM SETTLEMENT PRACTICES

22 Sec. 542.001. SHORT TITLE

23 Sec. 542.002. APPLICABILITY OF SUBCHAPTER

24 Sec. 542.003. UNFAIR CLAIM SETTLEMENT PRACTICES

25 PROHIBITED

26 Sec. 542.004. EXAMINATION OF TAX RETURNS PROHIBITED

27 Sec. 542.005. RECORD OF COMPLAINTS

1 Sec. 542.006. PERIODIC REPORTING REQUIREMENT

2 Sec. 542.007. COMPARISON OF CERTAIN INSURERS TO

3 MINIMUM STANDARD OF PERFORMANCE;

4 INVESTIGATION

5 Sec. 542.008. COMPLAINTS AGAINST INSURERS; INVESTIGATION

6 Sec. 542.009. REVIEW OF INVESTIGATION RESULTS; HEARING

7 Sec. 542.010. CEASE AND DESIST ORDER; ENFORCEMENT

8 Sec. 542.011. TIME LIMIT TO APPEAL

9 Sec. 542.012. ATTORNEY'S FEES

10 Sec. 542.013. PERSONNEL

11 Sec. 542.014. RULES

12 [Sections 542.015-542.050 reserved for expansion]

13 SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS

14 Sec. 542.051. DEFINITIONS

15 Sec. 542.052. APPLICABILITY OF SUBCHAPTER

16 Sec. 542.053. EXCEPTION

17 Sec. 542.054. LIBERAL CONSTRUCTION

18 Sec. 542.055. RECEIPT OF NOTICE OF CLAIM

19 Sec. 542.056. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM

20 Sec. 542.057. PAYMENT OF CLAIM

21 Sec. 542.058. DELAY IN PAYMENT OF CLAIM

22 Sec. 542.059. EXTENSION OF DEADLINES

23 Sec. 542.060. LIABILITY FOR VIOLATION OF SUBCHAPTER

24 Sec. 542.061. REMEDIES NOT EXCLUSIVE

25 [Sections 542.062-542.100 reserved for expansion]

26 SUBCHAPTER C. PROVIDING CERTAIN CLAIMS INFORMATION

27 ON REQUEST

1 Sec. 542.101. REQUEST BY NAMED INSURED UNDER LIABILITY

2 INSURANCE POLICY

3 Sec. 542.102. REQUEST BY POLICYHOLDER UNDER PROPERTY

4 AND CASUALTY INSURANCE POLICY

5 Sec. 542.103. DEADLINE FOR PROVIDING REQUESTED

6 INFORMATION

7 Sec. 542.104. RULES

8 [Sections 542.105-542.150 reserved for expansion]

9 SUBCHAPTER D. NOTICE OF SETTLEMENT OF CLAIM UNDER

10 CASUALTY INSURANCE POLICY

11 Sec. 542.151. APPLICABILITY OF SUBCHAPTER

12 Sec. 542.152. EXCEPTION

13 Sec. 542.153. NOTICE REQUIRED

14 Sec. 542.154. RULES

15 [Sections 542.155-542.200 reserved for expansion]

16 SUBCHAPTER E. COLLECTION FROM THIRD PARTIES UNDER CERTAIN

17 AUTOMOBILE INSURANCE POLICIES

18 Sec. 542.201. PURPOSE

19 Sec. 542.202. DEFINITION

20 Sec. 542.203. APPLICABILITY OF SUBCHAPTER

21 Sec. 542.204. ACTION TO RECOVER DEDUCTIBLE

22 Sec. 542.205. ENFORCEMENT; RULES

23 CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

24 SUBCHAPTER A. UNFAIR CLAIM SETTLEMENT PRACTICES

25 Sec. 542.001. SHORT TITLE. This subchapter may be cited as

26 the Unfair Claim Settlement Practices Act. (V.T.I.C. Art. 21.21-2,

27 Sec. 1.)

1 Sec. 542.002. APPLICABILITY OF SUBCHAPTER. This subchapter
2 applies to the following insurers whether organized as a
3 proprietorship, partnership, stock or mutual corporation, or
4 unincorporated association:

- 5 (1) a life, health, or accident insurance company;
- 6 (2) a fire or casualty insurance company;
- 7 (3) a hail or storm insurance company;
- 8 (4) a title insurance company;
- 9 (5) a mortgage guarantee company;
- 10 (6) a mutual assessment company;
- 11 (7) a local mutual aid association;
- 12 (8) a local mutual burial association;
- 13 (9) a statewide mutual assessment company;
- 14 (10) a stipulated premium company;
- 15 (11) a fraternal benefit society;
- 16 (12) a group hospital service corporation;
- 17 (13) a county mutual insurance company;
- 18 (14) a Lloyd's plan;
- 19 (15) a reciprocal or interinsurance exchange; and
- 20 (16) a farm mutual insurance company. (V.T.I.C. Art.
21 21.21-2, Sec. 7.)

22 Sec. 542.003. UNFAIR CLAIM SETTLEMENT PRACTICES
23 PROHIBITED. (a) An insurer engaging in business in this state may
24 not engage in an unfair claim settlement practice.

25 (b) Any of the following acts by an insurer constitutes
26 unfair claim settlement practices:

- 27 (1) knowingly misrepresenting to a claimant pertinent

1 facts or policy provisions relating to coverage at issue;

2 (2) failing to acknowledge with reasonable promptness
3 pertinent communications relating to a claim arising under the
4 insurer's policy;

5 (3) failing to adopt and implement reasonable
6 standards for the prompt investigation of claims arising under the
7 insurer's policies;

8 (4) not attempting in good faith to effect a prompt,
9 fair, and equitable settlement of a claim submitted in which
10 liability has become reasonably clear;

11 (5) compelling a policyholder to institute a suit to
12 recover an amount due under a policy by offering substantially less
13 than the amount ultimately recovered in a suit brought by the
14 policyholder;

15 (6) failing to maintain the information required by
16 Section 542.005; or

17 (7) committing another act the commissioner
18 determines by rule constitutes an unfair claim settlement practice.
19 (V.T.I.C. Art. 21.21-2, Secs. 2(a), (b) (part).)

20 Sec. 542.004. EXAMINATION OF TAX RETURNS PROHIBITED. (a)
21 An insurer regulated under this code may not require a claimant, as
22 a condition of settling a claim, to produce the claimant's federal
23 income tax returns for examination or investigation by the insurer
24 unless:

25 (1) the claimant is ordered to produce the tax returns
26 by a court; or

27 (2) the claim involves:

1 (A) a fire loss; or

2 (B) a loss of profits or income.

3 (b) An insurer that violates this section commits:

4 (1) a prohibited practice under this subchapter; and

5 (2) a deceptive trade practice under Subchapter E,
6 Chapter 17, Business & Commerce Code.

7 (c) A claimant affected by a violation of this section is
8 entitled to remedies under Subchapter E, Chapter 17, Business &
9 Commerce Code. (V.T.I.C. Art. 21.21-2, Sec. 2(c).)

10 Sec. 542.005. RECORD OF COMPLAINTS. (a) In this section,
11 "complaint" means any written communication primarily expressing a
12 grievance.

13 (b) An insurer shall maintain a complete record of all
14 complaints received by the insurer during the preceding three years
15 or since the date of the insurer's last examination by the
16 department, whichever period is shorter. The record must indicate:

17 (1) the total number of complaints;

18 (2) the classification of complaints by line of
19 insurance;

20 (3) the nature of each complaint;

21 (4) the disposition of the complaints; and

22 (5) the time spent processing each complaint.
23 (V.T.I.C. Art. 21.21-2, Sec. 2(b) (part).)

24 Sec. 542.006. PERIODIC REPORTING REQUIREMENT. (a) In this
25 section, "claim" means a written claim filed by a resident of this
26 state with an insurer engaging in business in this state.

27 (b) If, based on complaints of unfair claim settlement

1 practices under this subchapter, the department finds that an
2 insurer should be subjected to closer supervision with respect to
3 the insurer's claim settlement practices, the department may
4 require the insurer to file periodic reports at intervals the
5 department determines necessary.

6 (c) The department shall devise a statistical plan for the
7 periodic reports required under Subsection (b). The plan must
8 contain at a minimum:

9 (1) the following claims information for the preceding
10 12 months or from the date of the insurer's last periodic report,
11 whichever period is shorter:

12 (A) the total number of claims filed, including
13 for each individual claim:

14 (i) the original amount filed for by the
15 insured; and

16 (ii) the classification by line of
17 insurance;

18 (B) the total number of claims denied;

19 (C) the total number of claims settled, including
20 for each individual claim:

21 (i) the original amount filed for by the
22 insured;

23 (ii) the amount settled; and

24 (iii) the classification by line of
25 insurance; and

26 (D) the total number of claims for which suits
27 have been instituted against the insurer, including for each

1 individual claim:

2 (i) the original amount filed for by the
3 insured;

4 (ii) the amount of final adjudication;

5 (iii) the reason for the suit; and

6 (iv) the classification by line of
7 insurance; and

8 (2) the information required to be maintained by the
9 insurer under Section 542.005.

10 (d) If at any time the department determines that the
11 requirement to file a periodic report is no longer necessary to
12 accomplish the objectives of this subchapter, the department may
13 rescind the reporting requirement. (V.T.I.C. Art. 21.21-2, Sec.
14 3.)

15 Sec. 542.007. COMPARISON OF CERTAIN INSURERS TO MINIMUM
16 STANDARD OF PERFORMANCE; INVESTIGATION. (a) The department shall
17 compile the information received from an insurer under Section
18 542.006 in a manner that enables the department to compare the
19 insurer's performance to a minimum standard of performance adopted
20 by the commissioner.

21 (b) If the department determines that the insurer does not
22 meet the minimum standard of performance, the department shall
23 investigate the insurer to determine the reason, if any, that the
24 insurer does not meet the minimum standard. (V.T.I.C. Art.
25 21.21-2, Sec. 4(b).)

26 Sec. 542.008. COMPLAINTS AGAINST INSURERS; INVESTIGATION.
27 (a) The department shall establish a system for receiving and

1 processing individual complaints alleging a violation of this
2 subchapter by an insurer regardless of whether the insurer is
3 required to file a periodic report under Section 542.006.

4 (b) The department shall investigate an insurer if the
5 department determines that:

6 (1) based on the number and type of complaints against
7 an insurer, the insurer does not meet the minimum standard of
8 performance adopted under Section 542.007; or

9 (2) the number and type of complaints against the
10 insurer are not proportionate to the number and type of complaints
11 against other insurers writing similar lines of insurance.
12 (V.T.I.C. Art. 21.21-2, Sec. 4(c).)

13 Sec. 542.009. REVIEW OF INVESTIGATION RESULTS; HEARING.

14 (a) On receiving the results of an investigation instituted under
15 Section 542.007 or 542.008, the department shall review those
16 results considering the standards of this subchapter to determine
17 whether further action is necessary.

18 (b) If the department determines that further action is
19 necessary, the department shall:

20 (1) set a date for a hearing to review the alleged
21 violations of this subchapter; and

22 (2) notify the insurer of:

23 (A) the date of the hearing; and

24 (B) the nature of the charges.

25 (c) The department shall provide the notice required by
26 Subsection (b)(2) not later than the 30th day before the date of the
27 hearing.

1 (d) At a hearing under this section, the insurer may present
2 the insurer's case with the assistance of counsel.

3 (e) Evidence relating to the number and type of complaints
4 or claims prepared by the department from information received or
5 compiled under Section 542.006, 542.007, or 542.008 is admissible
6 in evidence at:

7 (1) the hearing; and

8 (2) any related judicial proceeding.

9 (f) The hearing shall be conducted in accordance with this
10 code and rules adopted by the commissioner.

11 (g) An insurer may not be found to be in violation of this
12 subchapter solely because of the number and type of complaints or
13 claims against the insurer. (V.T.I.C. Art. 21.21-2, Sec. 5(a).)

14 Sec. 542.010. CEASE AND DESIST ORDER; ENFORCEMENT. (a) If
15 the department determines that an insurer has violated this
16 subchapter, the department shall issue a cease and desist order to
17 the insurer directing the insurer to stop the unlawful practice.

18 (b) If the insurer fails to comply with the cease and desist
19 order, the department may:

20 (1) revoke or suspend the insurer's certificate of
21 authority; or

22 (2) limit, regulate, and control:

23 (A) the insurer's line of business;

24 (B) the insurer's writing of policy forms or
25 other particular forms; and

26 (C) the volume of the insurer's:

27 (i) line of business; or

1 (ii) writing of policy forms or other
2 particular forms.

3 (c) The department shall exercise authority under this
4 section to the extent that the department determines is necessary
5 to obtain the insurer's compliance with the cease and desist order.

6 (d) At the request of the department, the attorney general
7 shall assist the department in enforcing the cease and desist
8 order. (V.T.I.C. Art. 21.21-2, Sec. 6(a).)

9 Sec. 542.011. TIME LIMIT TO APPEAL. An insurer affected by
10 a ruling or order of the department under this subchapter may appeal
11 the ruling or order, in accordance with Subchapter D, Chapter 36, by
12 filing a petition for judicial review not later than the 20th day
13 after the date of the ruling or order. (V.T.I.C. Art. 21.21-2, Sec.
14 6(b) (part).)

15 Sec. 542.012. ATTORNEY'S FEES. The department is entitled
16 to reasonable attorney's fees if judicial action is necessary to
17 enforce an order of the department under this subchapter.
18 (V.T.I.C. Art. 21.21-2, Sec. 6(b) (part).)

19 Sec. 542.013. PERSONNEL. The department may hire employees
20 and examiners as needed to enforce this subchapter. (V.T.I.C. Art.
21 21.21-2, Sec. 4(a).)

22 Sec. 542.014. RULES. The commissioner shall adopt
23 reasonable rules as necessary to implement and augment the purposes
24 and provisions of this subchapter. (V.T.I.C. Art. 21.21-2, Sec.
25 8.)

26 [Sections 542.015-542.050 reserved for expansion]

27 SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS

1 Sec. 542.051. DEFINITIONS. In this subchapter:

2 (1) "Business day" means a day other than a Saturday,
3 Sunday, or holiday recognized by this state.

4 (2) "Claim" means a first-party claim that:

5 (A) is made by an insured or policyholder under
6 an insurance policy or contract or by a beneficiary named in the
7 policy or contract; and

8 (B) must be paid by the insurer directly to the
9 insured or beneficiary.

10 (3) "Claimant" means a person making a claim.

11 (4) "Notice of claim" means any written notification
12 provided by a claimant to an insurer that reasonably apprises the
13 insurer of the facts relating to the claim. (V.T.I.C. Art. 21.55,
14 Secs. 1(1), (2), (3), (5).)

15 Sec. 542.052. APPLICABILITY OF SUBCHAPTER. This subchapter
16 applies to any insurer authorized to engage in business as an
17 insurance company or to provide insurance in this state, including:

18 (1) a stock life, health, or accident insurance
19 company;

20 (2) a mutual life, health, or accident insurance
21 company;

22 (3) a stock fire or casualty insurance company;

23 (4) a mutual fire or casualty insurance company;

24 (5) a Mexican casualty insurance company;

25 (6) a Lloyd's plan;

26 (7) a reciprocal or interinsurance exchange;

27 (8) a fraternal benefit society;

- 1 (9) a stipulated premium company;
- 2 (10) a nonprofit legal services corporation;
- 3 (11) a statewide mutual assessment company;
- 4 (12) a local mutual aid association;
- 5 (13) a local mutual burial association;
- 6 (14) an association exempt under Section 887.102;
- 7 (15) a nonprofit hospital, medical, or dental service
- 8 corporation, including a corporation subject to Chapter 842;
- 9 (16) a county mutual insurance company;
- 10 (17) a farm mutual insurance company;
- 11 (18) a risk retention group;
- 12 (19) a purchasing group;
- 13 (20) an eligible surplus lines insurer; and
- 14 (21) except as provided by Section 542.053(b), a
- 15 guaranty association operating under Article 21.28-C or 21.28-D.
- 16 (V.T.I.C. Art. 21.55, Sec. 1(4).)

17 Sec. 542.053. EXCEPTION. (a) This subchapter does not
18 apply to:

- 19 (1) workers' compensation insurance;
- 20 (2) mortgage guaranty insurance;
- 21 (3) title insurance;
- 22 (4) fidelity, surety, or guaranty bonds;
- 23 (5) marine insurance other than inland marine
- 24 insurance governed by Article 5.53; or
- 25 (6) a guaranty association created and operating under
- 26 Chapter 2602.

27 (b) A guaranty association operating under Article 21.28-C

1 or 21.28-D is not subject to the damage provisions of Section
2 542.060.

3 (c) This subchapter does not apply to a health maintenance
4 organization except as provided by Section 1271.005(c).

5 (d) This subchapter does not apply to a claim governed by
6 Subchapter C, Chapter 1301. (V.T.I.C. Art. 21.55, Secs. 5(a), (b)
7 (part), (c).)

8 Sec. 542.054. LIBERAL CONSTRUCTION. This subchapter shall
9 be liberally construed to promote the prompt payment of insurance
10 claims. (V.T.I.C. Art. 21.55, Sec. 8.)

11 Sec. 542.055. RECEIPT OF NOTICE OF CLAIM. (a) Not later
12 than the 15th day or, if the insurer is an eligible surplus lines
13 insurer, the 30th business day after the date an insurer receives
14 notice of a claim, the insurer shall:

- 15 (1) acknowledge receipt of the claim;
16 (2) commence any investigation of the claim; and
17 (3) request from the claimant all items, statements,
18 and forms that the insurer reasonably believes, at that time, will
19 be required from the claimant.

20 (b) An insurer may make additional requests for information
21 if during the investigation of the claim the additional requests
22 are necessary.

23 (c) If the acknowledgment of receipt of a claim is not made
24 in writing, the insurer shall make a record of the date, manner, and
25 content of the acknowledgment. (V.T.I.C. Art. 21.55, Sec. 2.)

26 Sec. 542.056. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM.

27 (a) Except as provided by Subsection (b) or (d), an insurer shall

1 notify a claimant in writing of the acceptance or rejection of a
2 claim not later than the 15th business day after the date the
3 insurer receives all items, statements, and forms required by the
4 insurer to secure final proof of loss.

5 (b) If an insurer has a reasonable basis to believe that a
6 loss resulted from arson, the insurer shall notify the claimant in
7 writing of the acceptance or rejection of the claim not later than
8 the 30th day after the date the insurer receives all items,
9 statements, and forms required by the insurer.

10 (c) If the insurer rejects the claim, the notice required by
11 Subsection (a) or (b) must state the reasons for the rejection.

12 (d) If the insurer is unable to accept or reject the claim
13 within the period specified by Subsection (a) or (b), the insurer,
14 within that same period, shall notify the claimant of the reasons
15 that the insurer needs additional time. The insurer shall accept or
16 reject the claim not later than the 45th day after the date the
17 insurer notifies a claimant under this subsection. (V.T.I.C. Art.
18 21.55, Secs. 3(a), (b), (c), (d), (e).)

19 Sec. 542.057. PAYMENT OF CLAIM. (a) Except as otherwise
20 provided by this section, if an insurer notifies a claimant under
21 Section 542.056 that the insurer will pay a claim or part of a
22 claim, the insurer shall pay the claim not later than the fifth
23 business day after the date notice is made.

24 (b) If payment of the claim or part of the claim is
25 conditioned on the performance of an act by the claimant, the
26 insurer shall pay the claim not later than the fifth business day
27 after the date the act is performed.

1 (c) If the insurer is an eligible surplus lines insurer, the
2 insurer shall pay the claim not later than the 20th business day
3 after the notice or the date the act is performed, as applicable.
4 (V.T.I.C. Art. 21.55, Sec. 4.)

5 Sec. 542.058. DELAY IN PAYMENT OF CLAIM. (a) Except as
6 otherwise provided, if an insurer, after receiving all items,
7 statements, and forms reasonably requested and required under
8 Section 542.055, delays payment of the claim for a period exceeding
9 the period specified by other applicable statutes or, if other
10 statutes do not specify a period, for more than 60 days, the insurer
11 shall pay damages and other items as provided by Section 542.060.

12 (b) This section does not apply in a case in which it is
13 found as a result of arbitration or litigation that a claim received
14 by an insurer is invalid and should not be paid by the insurer.
15 (V.T.I.C. Art. 21.55, Secs. 3(f), (g).)

16 Sec. 542.059. EXTENSION OF DEADLINES. (a) A court may
17 grant a request by a guaranty association for an extension of the
18 periods under this subchapter on a showing of good cause and after
19 reasonable notice to policyholders.

20 (b) In the event of a weather-related catastrophe or major
21 natural disaster, as defined by the commissioner, the
22 claim-handling deadlines imposed under this subchapter are
23 extended for an additional 15 days. (V.T.I.C. Art. 21.55, Secs.
24 5(b) (part), (d).)

25 Sec. 542.060. LIABILITY FOR VIOLATION OF SUBCHAPTER. (a)
26 If an insurer that is liable for a claim under an insurance policy
27 is not in compliance with this subchapter, the insurer is liable to

1 pay the holder of the policy or the beneficiary making the claim
2 under the policy, in addition to the amount of the claim, interest
3 on the amount of the claim at the rate of 18 percent a year as
4 damages, together with reasonable attorney's fees.

5 (b) If a suit is filed, the attorney's fees shall be taxed as
6 part of the costs in the case. (V.T.I.C. Art. 21.55, Sec. 6.)

7 Sec. 542.061. REMEDIES NOT EXCLUSIVE. The remedies
8 provided by this subchapter are in addition to any other remedy or
9 procedure provided by law or at common law. (V.T.I.C. Art. 21.55,
10 Sec. 7.)

11 [Sections 542.062-542.100 reserved for expansion]

12 SUBCHAPTER C. PROVIDING CERTAIN CLAIMS INFORMATION

13 ON REQUEST

14 Sec. 542.101. REQUEST BY NAMED INSURED UNDER LIABILITY
15 INSURANCE POLICY. (a) In this section, "liability insurance"
16 means:

- 17 (1) general liability insurance;
18 (2) professional liability insurance, including
19 medical professional liability insurance;
20 (3) commercial automobile liability insurance; and
21 (4) the liability portion of commercial multiperil
22 insurance.

23 (b) On written request of a named insured under a liability
24 insurance policy, the insurer that wrote the policy shall provide
25 to the insured information relating to the disposition of a claim
26 filed under the policy. The information must include:

- 27 (1) the name of each claimant;

1 (2) details relating to:

2 (A) the amount paid on the claim;

3 (B) settlement of the claim; or

4 (C) judgment on the claim;

5 (3) details as to how the claim, settlement, or
6 judgment is to be paid; and

7 (4) any other information required by rule of the
8 commissioner that the commissioner considers necessary to
9 adequately inform an insured with regard to any claim under a
10 liability insurance policy.

11 (c) A request for information under this section must be
12 transmitted to the insurer not later than six months after the date
13 of disposition of the claim. (V.T.I.C. Art. 21.59, Secs. (a), (b),
14 (c), (f).)

15 Sec. 542.102. REQUEST BY POLICYHOLDER UNDER PROPERTY AND
16 CASUALTY INSURANCE POLICY. (a) On written request of a
17 policyholder, an insurer that writes property and casualty
18 insurance in this state shall provide the policyholder with a list
19 of claims charged against the policy and payments made on each
20 claim.

21 (b) This section does not apply to a workers' compensation
22 insurance policy subject to Article 5.65A. (V.T.I.C. Art. 21.59,
23 Sec. (d).)

24 Sec. 542.103. DEADLINE FOR PROVIDING REQUESTED
25 INFORMATION. (a) An insurer shall provide the information
26 requested under this subchapter in writing not later than the 30th
27 day after the date the insurer receives the request for the

1 information.

2 (b) For purposes of this section, information is considered
3 to be provided on the date the information is deposited with the
4 United States Postal Service or is personally delivered. (V.T.I.C.
5 Art. 21.59, Sec. (e).)

6 Sec. 542.104. RULES. The commissioner may by rule
7 prescribe forms for requesting information and for providing
8 requested information under this subchapter. (V.T.I.C. Art. 21.59,
9 Sec. (g).)

10 [Sections 542.105-542.150 reserved for expansion]

11 SUBCHAPTER D. NOTICE OF SETTLEMENT OF CLAIM UNDER

12 CASUALTY INSURANCE POLICY

13 Sec. 542.151. APPLICABILITY OF SUBCHAPTER. This subchapter
14 applies only to the settlement of a claim under a casualty insurance
15 policy that is delivered, issued for delivery, or renewed in this
16 state, including a policy written by:

- 17 (1) a county mutual insurance company;
18 (2) a Lloyd's plan;
19 (3) an eligible surplus lines insurer; or
20 (4) a reciprocal or interinsurance exchange.
21 (V.T.I.C. Art. 21.56, Sec. (a) (part).)

22 Sec. 542.152. EXCEPTION. This subchapter does not apply
23 to:

- 24 (1) a casualty insurance policy that requires the
25 insured's consent to settle a claim against the insured;
26 (2) fidelity, surety, or guaranty bonds; or
27 (3) marine insurance other than inland marine

1 insurance governed by Article 5.53. (V.T.I.C. Art. 21.56, Secs.
2 (a) (part), (e).)

3 Sec. 542.153. NOTICE REQUIRED. (a) Not later than the 10th
4 day after the date an initial offer to settle a claim against a
5 named insured under a casualty insurance policy issued to the
6 insured is made, the insurer shall notify the insured in writing of
7 the offer.

8 (b) Not later than the 30th day after the date a claim
9 against a named insured under a casualty insurance policy issued to
10 the insured is settled, the insurer shall notify the insured in
11 writing of the settlement. (V.T.I.C. Art. 21.56, Secs. (b), (c).)

12 Sec. 542.154. RULES. The commissioner may adopt rules to
13 implement this subchapter. (V.T.I.C. Art. 21.56, Sec. (d).)

14 [Sections 542.155-542.200 reserved for expansion]

15 SUBCHAPTER E. COLLECTION FROM THIRD PARTIES UNDER CERTAIN
16 AUTOMOBILE INSURANCE POLICIES

17 Sec. 542.201. PURPOSE. This subchapter is intended to
18 encourage insurers to take appropriate and necessary steps to
19 collect from third parties or the insurers of the third parties.
20 (V.T.I.C. Art. 21.79G, Sec. (e) (part).)

21 Sec. 542.202. DEFINITION. In this subchapter, "action"
22 includes taking various actions such as reasonable and diligent
23 collection efforts, mediation, arbitration, and litigation against
24 a responsible third party or the third party's insurer. (V.T.I.C.
25 Art. 21.79G, Sec. (e) (part).)

26 Sec. 542.203. APPLICABILITY OF SUBCHAPTER. This subchapter
27 applies to any insurer that delivers, issues for delivery, or

1 renews in this state a private passenger automobile insurance
2 policy, including a reciprocal or interinsurance exchange, mutual
3 insurance company, association, Lloyd's plan, or other insurer.
4 (V.T.I.C. Art. 21.79G, Sec. (a).)

5 Sec. 542.204. ACTION TO RECOVER DEDUCTIBLE. (a)
6 Notwithstanding any other provision of this code and except as
7 provided by Subsection (b), if an insurer is liable to an insured
8 for a claim that is subject to a deductible payable by the insured
9 and a third party may be liable to the insurer or the insured for the
10 amount of the deductible, the insurer shall:

11 (1) take action to recover the deductible against the
12 third party not later than the first anniversary of the date the
13 insured's claim is paid; or

14 (2) pay the amount of the deductible to the insured.

15 (b) An insurer is not required to take action or pay the
16 amount of the deductible as required by Subsection (a) if, not later
17 than the earlier of the first anniversary of the date the insured's
18 claim is paid or the 90th day before the date the statute of
19 limitations for a negligence action expires, the insurer:

20 (1) notifies the insured in writing that the insurer
21 does not intend to take further collection actions against the
22 third party; and

23 (2) authorizes the insured to take further collection
24 actions.

25 (c) This section applies regardless of whether the third
26 party who may be liable for the amount of the deductible is insured
27 or uninsured. (V.T.I.C. Art. 21.79G, Secs. (b), (c), (d).)

1 Sec. 542.205. ENFORCEMENT; RULES. The commissioner may
2 enforce this subchapter and adopt and enforce reasonable rules
3 necessary to accomplish the purposes of this subchapter. (V.T.I.C.
4 Art. 21.79G, Sec. (f).)

5 CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY

6 OR CERTIFICATE OF MEMBERSHIP

7 SUBCHAPTER A. PROHIBITIONS

8 Sec. 543.001. MISREPRESENTATION PROHIBITED

9 Sec. 543.002. CONTRACT EXPRESSED IN POLICY ONLY

10 Sec. 543.003. THING OF VALUE NOT SPECIFIED IN

11 POLICY

12 Sec. 543.004. SHARING OF OR PARTICIPATION IN

13 SPECIAL FUND PROHIBITED

14 [Sections 543.005-543.050 reserved for expansion]

15 SUBCHAPTER B. ENFORCEMENT; PENALTY

16 Sec. 543.051. SUSPENSION OR REVOCATION OF CERTIFICATE,

17 CHARTER, PERMIT, OR LICENSE

18 Sec. 543.052. CRIMINAL PENALTY

19 CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY

20 OR CERTIFICATE OF MEMBERSHIP

21 SUBCHAPTER A. PROHIBITIONS

22 Sec. 543.001. MISREPRESENTATION PROHIBITED. (a) In this
23 section, "life, health, or casualty insurer" includes a corporation
24 operating on a cooperative or assessment plan, a mutual insurance
25 company, a fraternal benefit society, and any other society or
26 association authorized to issue an insurance policy in this state.

27 (b) A life, health, or casualty insurer, an officer,

1 director, agent, or representative of that insurer, or any other
2 person, corporation, or copartnership may not:

3 (1) issue, circulate, or cause or permit to be issued
4 or circulated any statement, including an illustration or estimate,
5 that misrepresents:

6 (A) the terms of a policy or certificate of
7 membership issued by a life, health, or casualty insurer;

8 (B) other benefits or advantages provided by the
9 policy or certificate; or

10 (C) the dividends or share of surplus to be
11 received on the policy or certificate;

12 (2) use a name or title of a policy, policy class,
13 certificate of membership, or certificate class that misrepresents
14 the policy, certificate, or class; or

15 (3) make a misleading representation or incomplete
16 comparison of a policy or certificate of membership to an insured or
17 member for the purpose of inducing or tending to induce the insured
18 or member to forfeit, surrender, or allow the lapse of the insurance
19 or membership.

20 (c) The commissioner may adopt and enforce reasonable rules
21 as provided by Subchapter I, Chapter 541, to accomplish the
22 purposes of Subsection (b)(1) as those purposes relate to life
23 insurance companies. (V.T.I.C. Art. 21.20; Art. 21.21, Sec. 13
24 (part); Art. 21.21A, Sec. 2.)

25 Sec. 543.002. CONTRACT EXPRESSED IN POLICY ONLY. An
26 insurer or an agent of an insurer may not make an insurance contract
27 or an agreement relating to an insurance contract other than as

expressed in the policy issued in connection with the contract.
(V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Sec. 543.003. THING OF VALUE NOT SPECIFIED IN POLICY. An insurer or an officer, agent, or representative of an insurer may not:

(1) directly or indirectly pay, allow, or give or offer to pay, allow, or give as an inducement to insurance a thing of value or other inducement that is not specified in the policy, including:

(A) a rebate of premium payable on the policy;

(B) a special favor or advantage in the dividends or other benefits to accrue on the policy; or

(C) paid employment or a contract for service; or

(2) give, sell, or purchase or offer to give, sell, or purchase as an inducement to insurance or in connection with insurance a thing of value that is not specified in the policy, including:

(A) stocks, bonds, or other securities of an insurer or other corporation, association, or partnership; or

(B) dividends or profits to accrue on the stocks, bonds, or other securities of an insurer or other corporation, association, or partnership. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Sec. 543.004. SHARING OF OR PARTICIPATION IN SPECIAL FUND PROHIBITED. An insurer or an officer, agent, or representative of an insurer may not issue a policy that contains a special or board contract or similar provision by the terms of which the policy will

1 share or participate in a special fund derived from a tax or a
2 charge against any portion of the premium on another policy.
3 (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

4 [Sections 543.005-543.050 reserved for expansion]

5 SUBCHAPTER B. ENFORCEMENT; PENALTY

6 Sec. 543.051. SUSPENSION OR REVOCATION OF CERTIFICATE,
7 CHARTER, PERMIT, OR LICENSE. (a) On a hearing, the commissioner
8 may suspend or revoke the certificate, charter, permit, or license
9 to engage in the business of insurance of a society, association,
10 corporation, or person that violates Subchapter A.

11 (b) The commissioner must give 10 days' notice of the
12 hearing by certified mail to the society, association, corporation,
13 or person. (V.T.I.C. Art. 21.21A, Sec. 4.)

14 Sec. 543.052. CRIMINAL PENALTY. (a) A person commits an
15 offense if the person violates Subchapter A.

16 (b) An offense under this section is a Class A misdemeanor.

17 (c) The penalty provided by this section is in addition to
18 any other penalty specifically provided by law. (V.T.I.C. Art.
19 21.21A, Sec. 3.)

20 CHAPTER 544. PROHIBITED DISCRIMINATION

21 SUBCHAPTER A. GENERAL PROHIBITIONS AGAINST DISCRIMINATION

22 BY AN INSURER OR HEALTH MAINTENANCE ORGANIZATION

23 Sec. 544.001. APPLICABILITY OF SUBCHAPTER

24 Sec. 544.002. UNFAIR DISCRIMINATION

25 Sec. 544.003. EXCEPTIONS

26 Sec. 544.004. ENFORCEMENT ACTIONS

27 [Sections 544.005-544.050 reserved for expansion]

SUBCHAPTER B. OTHER GENERAL PROHIBITIONS AGAINST
DISCRIMINATION BY INSURERS

Sec. 544.051. APPLICABILITY OF SUBCHAPTER

Sec. 544.052. UNFAIR DISCRIMINATION

Sec. 544.053. EXCEPTIONS

Sec. 544.054. JUDICIAL ACTION; AWARD BY COURT

[Sections 544.055-544.100 reserved for expansion]

SUBCHAPTER C. ENGLISH FLUENCY

Sec. 544.101. DEFINITIONS

Sec. 544.102. APPLICABILITY OF SUBCHAPTER

Sec. 544.103. PROHIBITION ON USE OF CERTAIN GUIDELINES

[Sections 544.104-544.150 reserved for expansion]

SUBCHAPTER D. FAMILY VIOLENCE

Sec. 544.151. DEFINITION

Sec. 544.152. APPLICABILITY OF SUBCHAPTER

Sec. 544.153. PROHIBITIONS

Sec. 544.154. CONFIDENTIALITY OF CERTAIN INFORMATION

Sec. 544.155. UNDERWRITING CRITERIA

Sec. 544.156. HEALTH BENEFIT PLAN ISSUER OR LIFE INSURER NOT

LIABLE FOR DEATH OR BODILY INJURY

Sec. 544.157. RIGHT TO CONTINUED COVERAGE UNAFFECTED

Sec. 544.158. UNFAIR OR DECEPTIVE ACT OR PRACTICE

[Sections 544.159-544.200 reserved for expansion]

SUBCHAPTER E. FIBROCYSTIC BREAST CONDITION

Sec. 544.201. DEFINITION

Sec. 544.202. PROHIBITION

Sec. 544.203. UNFAIR OR DECEPTIVE ACT OR PRACTICE

1 Sec. 544.204. PAYMENT FOR DISEASE NOT REQUIRED

2 [Sections 544.205-544.250 reserved for expansion]

3 SUBCHAPTER F. CHURCH PROPERTY

4 Sec. 544.251. DEFINITIONS

5 Sec. 544.252. APPLICABILITY OF SUBCHAPTER

6 Sec. 544.253. PROHIBITION

7 Sec. 544.254. UNFAIR OR DECEPTIVE ACT OR PRACTICE

8 CHAPTER 544. PROHIBITED DISCRIMINATION

9 SUBCHAPTER A. GENERAL PROHIBITIONS AGAINST DISCRIMINATION

10 BY AN INSURER OR HEALTH MAINTENANCE ORGANIZATION

11 Sec. 544.001. APPLICABILITY OF SUBCHAPTER. This subchapter
12 applies to:

13 (1) any legal entity engaged in the business of
14 insurance in this state, including:

15 (A) a capital stock insurance company;

16 (B) a mutual insurance company;

17 (C) a title insurance company;

18 (D) a fraternal benefit society;

19 (E) a local mutual aid association;

20 (F) a statewide mutual assessment company;

21 (G) a county mutual insurance company;

22 (H) a Lloyd's plan;

23 (I) a reciprocal or interinsurance exchange;

24 (J) a stipulated premium company;

25 (K) a group hospital service corporation;

26 (L) a farm mutual insurance company;

27 (M) a risk retention group;

(N) an eligible surplus lines insurer; and

(O) an agent, broker, adjuster, or life and health insurance counselor; and

(2) a health maintenance organization. (V.T.I.C. Art. 21.21-6, Sec. 2, as added Acts 74th Leg., R.S., Ch. 415.)

Sec. 544.002. UNFAIR DISCRIMINATION. (a) A person may not refuse to insure or provide coverage to an individual, refuse to continue to insure or provide coverage to an individual, limit the amount, extent, or kind of coverage available for an individual, or charge an individual a rate that is different from the rate charged to other individuals for the same coverage because of the individual's:

(1) race, color, religion, or national origin;

(2) age, gender, marital status, or geographic location; or

(3) disability or partial disability.

(b) Subsection (a)(2) does not prohibit an insurer or health maintenance organization from considering marital status in defining persons eligible for dependent benefits.

(c) Subsection (a) does not prevent requirements to provide title insurance coverage relating to possible community, homestead, or other marital rights in land. (V.T.I.C. Art. 21.21-6, Secs. 1, 3, 4(e) (part), as added Acts 74th Leg., R.S., Ch. 415.)

Sec. 544.003. EXCEPTIONS. (a) A person does not violate Section 544.002 by providing coverage only to persons who are required to obtain or maintain membership or qualification for

1 membership in a club, group, or organization to be eligible for
2 coverage if:

3 (1) the requirements are uniform requirements of the
4 insurer or health maintenance organization as a condition of
5 providing coverage and are applied uniformly throughout this state;
6 and

7 (2) the person does not engage in an act prohibited
8 under Section 544.002 against a qualified member, except as
9 provided by this section.

10 (b) A person does not violate Section 544.002(a)(2) or (3)
11 if the refusal, limitation, or charge is based on sound
12 underwriting or actuarial principles reasonably related to actual
13 or anticipated loss experience. For the purposes of this
14 subsection, a refusal, limitation, or charge relating to title
15 insurance is based on sound actuarial principles if the action is
16 based on an examination of title or on closing the transaction.

17 (c) A person does not violate Section 544.002 if the
18 refusal, limitation, or charge is required or authorized by law or a
19 regulatory mandate.

20 (d) A person does not violate Section 544.002 if
21 policyholders or enrollees with similar expense factors but
22 different loss exposures are charged different premiums or rates
23 under a mass marketing plan. The commissioner by rule shall define
24 selected groups eligible for issuance of policies or evidences of
25 coverage under a mass marketing plan. (V.T.I.C. Art. 21.21-6,
26 Secs. 4(a), (b), (c), (d), (e) (part), as added Acts 74th Leg.,
27 R.S., Ch. 415.)

1 Sec. 544.004. ENFORCEMENT ACTIONS. (a) A legal entity
2 engaged in the business of insurance or a health maintenance
3 organization, that is found to be in violation of or to have failed
4 to comply with this subchapter, is subject to the sanctions
5 provided by Chapter 82, including administrative penalties
6 authorized under Chapter 84.

7 (b) In addition to the procedures provided by Subsection
8 (a), the commissioner may use the cease and desist procedures
9 authorized by Chapter 83. (V.T.I.C. Art. 21.21-6, Sec. 5, as added
10 Acts 74th Leg., R.S., Ch. 415.)

11 [Sections 544.005-544.050 reserved for expansion]

12 SUBCHAPTER B. OTHER GENERAL PROHIBITIONS AGAINST
13 DISCRIMINATION BY INSURERS

14 Sec. 544.051. APPLICABILITY OF SUBCHAPTER. This subchapter
15 applies to any individual, corporation, association, partnership,
16 or other legal entity engaged in the business of insurance,
17 including:

- 18 (1) a fraternal benefit society;
19 (2) a county mutual insurance company;
20 (3) a Lloyd's plan;
21 (4) a reciprocal or interinsurance exchange;
22 (5) a farm mutual insurance company; and
23 (6) an agent, broker, adjuster, or life and health
24 insurance counselor. (V.T.I.C. Art. 21.21-8, Sec. 1.)

25 Sec. 544.052. UNFAIR DISCRIMINATION. A person may not in
26 any manner engage in unfair discrimination or permit unfair
27 discrimination between individuals of the same class and of

1 essentially the same hazard, including unfair discrimination in:

2 (1) the amount of premium, policy fees, or rates
3 charged for a policy or contract of insurance;

4 (2) the benefits payable under a policy or contract of
5 insurance; or

6 (3) any of the terms or conditions of a policy or
7 contract of insurance. (V.T.I.C. Art. 21.21-8, Sec. 2.)

8 Sec. 544.053. EXCEPTIONS. (a) A person does not violate
9 Section 544.052 if the refusal to insure or to continue to insure,
10 the limiting of the amount, extent, or kind of coverage, or the
11 charging of an individual a rate that is different from the rate
12 charged another individual for the same coverage is based on sound
13 actuarial principles.

14 (b) A person does not violate Section 544.052 by providing
15 insurance coverage only to persons who are required to obtain or
16 maintain membership or qualification for membership in a club,
17 group, or organization to be eligible for coverage if:

18 (1) the requirements are uniform requirements of the
19 insurer as a condition of providing insurance and are applied
20 uniformly throughout this state; and

21 (2) the person does not engage in an act prohibited
22 under Section 544.052 against a qualified member, except as
23 provided by this section. (V.T.I.C. Art. 21.21-8, Secs. 4, 5.)

24 Sec. 544.054. JUDICIAL ACTION; AWARD BY COURT. (a) A
25 person who has sustained economic damages as the result of a
26 violation of Section 544.052 may maintain only in a Travis County
27 district court an action against the person who violated that

1 section.

2 (b) An action under this section must be commenced before
3 the first anniversary of the date on which the plaintiff was denied
4 insurance or the unfair act occurred.

5 (c) A plaintiff who prevails in an action under this section
6 may obtain:

7 (1) the amount of economic damages, court costs, and
8 attorney's fees; and

9 (2) an order enjoining the violation.

10 (d) Court costs under Subsection (c) may include any
11 reasonable and necessary expert witness fees.

12 (e) If the trier of fact finds that the defendant knowingly
13 committed an act prohibited by Section 544.052, the court may award
14 a civil penalty in an amount of not more than \$25,000 for each
15 claimant.

16 (f) The court shall award the defendant reasonable and
17 necessary attorney's fees if the court finds that an action under
18 this section was:

19 (1) groundless; and

20 (2) brought in bad faith or for the purpose of
21 harassment. (V.T.I.C. Art. 21.21-8, Sec. 3.)

22 [Sections 544.055-544.100 reserved for expansion]

23 SUBCHAPTER C. ENGLISH FLUENCY

24 Sec. 544.101. DEFINITIONS. In this subchapter:

25 (1) "Health benefit plan issuer" means an insurance
26 company, association, organization, group hospital service
27 corporation, or health maintenance organization that delivers or

1 issues for delivery an individual, group, blanket, or franchise
2 insurance policy or insurance agreement, a group hospital service
3 contract, or an evidence of coverage that provides health insurance
4 or health care benefits. The term includes:

5 (A) a life, health, and accident insurance
6 company operating under Chapter 841 or 982;

7 (B) a general casualty insurance company
8 operating under Chapter 861;

9 (C) a fraternal benefit society operating under
10 Chapter 885;

11 (D) a mutual life insurance company operating
12 under Chapter 882;

13 (E) a local mutual aid association operating
14 under Chapter 886;

15 (F) a statewide mutual assessment company
16 operating under Chapter 881;

17 (G) a mutual assessment company or mutual
18 assessment life, health, and accident association operating under
19 Chapter 887;

20 (H) a mutual insurance company operating under
21 Chapter 883 that writes coverage other than life insurance;

22 (I) a Lloyd's plan operating under Chapter 941;

23 (J) a reciprocal exchange operating under
24 Chapter 942; and

25 (K) a stipulated premium company operating under
26 Chapter 884.

27 (2) "Underwriting guideline" means a written,

1 electronic, or oral rule, standard, marketing decision, or practice
2 that is used by a health benefit plan issuer or an agent of a health
3 benefit plan issuer to examine, bind, accept, reject, renew or
4 refuse to renew, cancel, or limit coverages available to classes of
5 consumers or charge a different rate for the same coverage.
6 (V.T.I.C. Art. 21.21-7, Sec. 1.)

7 Sec. 544.102. APPLICABILITY OF SUBCHAPTER. This subchapter
8 applies to any health insurance policy, agreement, contract, or
9 evidence of coverage delivered or issued for delivery by a health
10 benefit plan issuer. (V.T.I.C. Art. 21.21-7, Sec. 2.)

11 Sec. 544.103. PROHIBITION ON USE OF CERTAIN GUIDELINES.
12 (a) A health benefit plan issuer may not use an underwriting
13 guideline that is based on:

14 (1) the ability of an insured or enrollee or an
15 applicant for insurance coverage or health care benefits to speak
16 English fluently; or

17 (2) the literacy in English of the insured, enrollee,
18 or applicant.

19 (b) An applicant has the burden of proof to establish a
20 violation of this subchapter. (V.T.I.C. Art. 21.21-7, Sec. 3.)

21 [Sections 544.104-544.150 reserved for expansion]

22 SUBCHAPTER D. FAMILY VIOLENCE

23 Sec. 544.151. DEFINITION. In this subchapter, "family
24 violence" means an act between individuals who reside together or
25 resided together in which one individual:

26 (1) wilfully attempts to cause bodily injury, or
27 wilfully or wantonly causes bodily injury, to another;

1 (2) wilfully by physical threat places another in fear
2 of imminent bodily injury;

3 (3) engages in the act of sexual intercourse with a
4 minor under 16 years of age who is not the spouse of the individual;
5 or

6 (4) engages, with the intent to arouse or to satisfy
7 the sexual desires of the individual, a minor under 16 years of age
8 who is not the spouse of the individual, or both the individual and
9 the minor, in any lewd fondling or touching of the individual or the
10 minor. (V.T.I.C. Art. 21.21-5, Sec. 1.)

11 Sec. 544.152. APPLICABILITY OF SUBCHAPTER. (a) This
12 subchapter applies only to:

13 (1) a life insurer that delivers, issues for delivery,
14 or renews a life insurance contract or policy in this state,
15 including a group contract, policy, or certificate of life
16 insurance; and

17 (2) a health benefit plan issuer that provides
18 benefits for medical or surgical expenses incurred as a result of a
19 health condition, accident, or sickness, including:

20 (A) an insurance company;

21 (B) a group hospital service corporation
22 operating under Chapter 842;

23 (C) a fraternal benefit society operating under
24 Chapter 885;

25 (D) a stipulated premium company operating under
26 Chapter 884;

27 (E) a health benefit plan issuer under Chapter

1501;

(F) a health maintenance organization operating under Chapter 843;

(G) an employer under a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002), or an analogous benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(H) an issuer of a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss); and

(I) an approved nonprofit health corporation that holds a certificate of authority issued under Chapter 844.

(b) This subchapter does not apply to the issuer of:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) only for limited benefits; or

(F) only for dental or vision care;

(2) hospital confinement indemnity coverage;

(3) a credit insurance policy;

(4) workers' compensation insurance coverage;

1 (5) medical payment insurance coverage provided under
2 a motor vehicle insurance policy; or

3 (6) a long-term care policy, including a nursing home
4 fixed indemnity policy, unless the commissioner determines that the
5 policy provides benefit coverage so comprehensive that the policy
6 is a health benefit plan as described by Subsection (a)(2).
7 (V.T.I.C. Art. 21.21-5, Sec. 2.)

8 Sec. 544.153. PROHIBITIONS. (a) A health benefit plan
9 issuer or life insurer may not, because of an individual's status as
10 a victim of family violence:

11 (1) deny coverage to the individual;
12 (2) refuse to renew the individual's coverage;
13 (3) cancel the individual's coverage;
14 (4) limit the amount, extent, or kind of coverage
15 available to the individual; or

16 (5) charge the individual or a group to which the
17 individual belongs a rate that is different from the rate charged to
18 other individuals or groups, respectively, for the same coverage.

19 (b) A health benefit plan issuer or life insurer may not, as
20 a part of an application for coverage, require an applicant to
21 reveal whether the applicant has been or may become a victim of
22 family violence. (V.T.I.C. Art. 21.21-5, Sec. 3.)

23 Sec. 544.154. CONFIDENTIALITY OF CERTAIN INFORMATION. (a)
24 Except as provided by Subsection (b), a health benefit plan issuer,
25 life insurer, or person employed by or under contract with a health
26 benefit plan issuer or life insurer may not release information
27 relating to the status as a victim of family violence of an

1 individual who is clearly a victim of family violence, including:

2 (1) information about specific acts of family violence
3 directed at the individual;

4 (2) the individual's address or telephone number at
5 home or at work; and

6 (3) information about the individual's employment,
7 associations, family membership, or relationships.

8 (b) A health benefit plan issuer or life insurer may release
9 information to which Subsection (a) applies only:

10 (1) to the individual;

11 (2) to another individual designated in writing by the
12 individual;

13 (3) to a licensed physician designated by the
14 individual;

15 (4) to a physician or other health care provider for
16 the provision of health care services;

17 (5) to an attorney who needs the information to
18 effectively represent the issuer or insurer, if the issuer or
19 insurer notifies the attorney of the requirements of this
20 subchapter and requests that the attorney exercise due diligence to
21 protect the information consistent with the attorney's obligation
22 to represent the issuer or insurer;

23 (6) to an individual covered under, or the owner of,
24 the health benefit plan or life insurance contract or policy that
25 contains information about status as a victim of family violence;

26 (7) to an individual or entity to whom the
27 commissioner considers the release appropriate;

1 (8) as required by other law or an order of the
2 commissioner or a court; or

3 (9) as necessary for a valid business purpose if:

4 (A) the information cannot be segregated from
5 other information about the individual without undue hardship to
6 the issuer or insurer;

7 (B) the recipient of the information is:

8 (i) a reinsurer that seeks to indemnify or
9 indemnifies all or part of a health benefit plan or life insurance
10 contract or policy covering the individual if the reinsurer cannot
11 underwrite or satisfy obligations under the reinsurance agreement
12 without the release of the information;

13 (ii) a party to a proposed or consummated
14 sale, transfer, merger, or consolidation of all or part of the
15 business of the issuer or insurer;

16 (iii) medical or claims personnel under
17 contract with the issuer or insurer, including a parent or
18 affiliate company under a service agreement with the issuer or
19 insurer, if the release of the information is necessary to process
20 an application, to perform duties under the health benefit plan or
21 life insurance contract or policy, or to protect the safety or
22 privacy of a victim of family violence; or

23 (iv) an entity with which the issuer
24 transacts business if the information is only the address or
25 telephone number of the individual and the entity cannot transact
26 the business without the address or telephone number; and

27 (C) the recipient of the information agrees in

1 writing to be subject to the requirements of this subchapter.
2 (V.T.I.C. Art. 21.21-5, Sec. 8.)

3 Sec. 544.155. UNDERWRITING CRITERIA. Notwithstanding any
4 other provision of this subchapter, a health benefit plan issuer or
5 life insurer may underwrite a risk on the basis of an individual's
6 physical or mental condition regardless of the underlying cause of
7 the condition or on the basis of any underwriting criteria not
8 prohibited by this code or another insurance law of this state or a
9 rule adopted under this code or another insurance law of this state
10 if the issuer or insurer consistently applies the criteria and does
11 not merely use the criteria as a pretext to evade the application of
12 Section 544.153. (V.T.I.C. Art. 21.21-5, Sec. 6.)

13 Sec. 544.156. HEALTH BENEFIT PLAN ISSUER OR LIFE INSURER
14 NOT LIABLE FOR DEATH OR BODILY INJURY. A health benefit plan issuer
15 or life insurer that delivers, issues for delivery, or renews a
16 health benefit plan or a life insurance policy or contract for an
17 individual who has been or may become a victim of family violence
18 may not be held civilly or criminally liable for the death of or
19 bodily injuries incurred by that individual as a result of family
20 violence. (V.T.I.C. Art. 21.21-5, Sec. 5.)

21 Sec. 544.157. RIGHT TO CONTINUED COVERAGE UNAFFECTED. This
22 subchapter does not affect the right of an individual to continued
23 coverage under Subchapter G, Chapter 1251. (V.T.I.C. Art. 21.21-5,
24 Sec. 7.)

25 Sec. 544.158. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A
26 violation of this subchapter is an unfair or deceptive act or
27 practice under Chapter 541. (V.T.I.C. Art. 21.21-5, Sec. 4.)

[Sections 544.159-544.200 reserved for expansion]

SUBCHAPTER E. FIBROCYSTIC BREAST CONDITION

Sec. 544.201. DEFINITION. In this subchapter, "health benefit plan issuer" means an insurer, a group hospital service corporation operating under Chapter 842, or a health maintenance organization operating under Chapter 843 that delivers or issues for delivery or renews any health insurance policy or contract in this state, including a group policy, contract, or certificate of health insurance or evidence of coverage. (V.T.I.C. Art. 21.21-6, Sec. (a), as added Acts 74th Leg., R.S., Ch. 522.)

Sec. 544.202. PROHIBITION. A health benefit plan issuer may not, solely or in part because an individual has been diagnosed with or has a history of a fibrocystic breast condition:

- (1) deny coverage to the individual;
- (2) refuse to renew the individual's coverage;
- (3) cancel the individual's coverage;
- (4) limit the amount, extent, or kind of coverage available to the individual for any other breast condition; or
- (5) charge the individual or a group to which the individual belongs a rate that is different from the rate charged to other individuals or groups, respectively, for the same coverage. (V.T.I.C. Art. 21.21-6, Sec. (b), as added Acts 74th Leg., R.S., Ch. 522.)

Sec. 544.203. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A violation of this subchapter is an unfair or deceptive act or practice under Chapter 541. (V.T.I.C. Art. 21.21-6, Sec. (c), as added Acts 74th Leg., R.S., Ch. 522.)

1 Sec. 544.204. PAYMENT FOR DISEASE NOT REQUIRED. This
2 subchapter does not require a health benefit plan issuer to pay
3 benefits for fibrocystic breast disease. (V.T.I.C. Art. 21.21-6,
4 Sec. (d), as added Acts 74th Leg., R.S., Ch. 522.)

5 [Sections 544.205-544.250 reserved for expansion]

6 SUBCHAPTER F. CHURCH PROPERTY

7 Sec. 544.251. DEFINITIONS. In this subchapter:

8 (1) "Church" means a facility that is owned by a
9 religious organization and is used primarily for religious
10 services.

11 (2) "Religious organization" means a church,
12 synagogue, or other organization or association organized
13 primarily for religious purposes. (V.T.I.C. Art. 21.21-9, Sec. 1,
14 as added Acts 75th Leg., R.S., Ch. 1007.)

15 Sec. 544.252. APPLICABILITY OF SUBCHAPTER. This subchapter
16 applies to an insurer that is admitted to engage in the business of
17 insurance and authorized to write an insurance policy providing
18 coverage for losses resulting from fire in this state, including a
19 county mutual insurance company, a Lloyd's plan, a reciprocal or
20 interinsurance exchange, or a farm mutual insurance company.
21 (V.T.I.C. Art. 21.21-9, Sec. 2, as added Acts 75th Leg., R.S., Ch.
22 1007.)

23 Sec. 544.253. PROHIBITION. An insurer writing insurance
24 for a church may not cancel or decline to renew an insurance policy
25 solely because of:

26 (1) an occurrence of arson against the church, if the
27 religious organization that owns the church cooperated with police,

1 fire, and other authorities in the investigation of the arson and in
2 the prosecution of those responsible for the arson; or

3 (2) a verbal or written threat of arson against the
4 church that was directed to the religious organization or an
5 official of the religious organization and that the organization or
6 official reported to the appropriate law enforcement agency within
7 a reasonable amount of time. (V.T.I.C. Art. 21.21-9, Sec. 3, as
8 added Acts 75th Leg., R.S., Ch. 1007.)

9 Sec. 544.254. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A
10 violation of this subchapter is an unfair or deceptive act or
11 practice in the business of insurance under Chapter 541. (V.T.I.C.
12 Art. 21.21-9, Sec. 4, as added Acts 75th Leg., R.S., Ch. 1007.)

13 CHAPTER 545. HIV TESTING

14 SUBCHAPTER A. GENERAL PROVISIONS

15 Sec. 545.001. DEFINITIONS

16 Sec. 545.002. EXCLUSIVE APPLICABILITY

17 Sec. 545.003. RULES

18 [Sections 545.004-545.050 reserved for expansion]

19 SUBCHAPTER B. ISSUER POWERS AND DUTIES

20 Sec. 545.051. HIV-RELATED TESTING AUTHORIZED

21 Sec. 545.052. NONDISCRIMINATORY BASIS REQUIRED

22 Sec. 545.053. EXPLANATION AND AUTHORIZATION REQUIRED

23 Sec. 545.054. INQUIRIES REGARDING PREVIOUS TESTS

24 Sec. 545.055. NOTICE OF POSITIVE TEST RESULT; FEE

25 Sec. 545.056. ADVERSE UNDERWRITING DECISION; TEST

26 PROTOCOL RULES

27 Sec. 545.057. CONFIDENTIALITY OF TEST RESULT REQUIRED

[Sections 545.058-545.700 reserved for expansion]

SUBCHAPTER O. SANCTIONS; PENALTIES; INJUNCTIONS

Sec. 545.701. SANCTIONS

Sec. 545.702. CIVIL ACTION; PENALTY

Sec. 545.703. CRIMINAL PENALTY

CHAPTER 545. HIV TESTING

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 545.001. DEFINITIONS. In this chapter:

(1) "AIDS" has the meaning assigned by Section 81.101, Health and Safety Code.

(2) "Applicant" means an individual who applies to an issuer for coverage.

(3) "HIV" has the meaning assigned by Section 81.101, Health and Safety Code.

(4) "Issuer" means a person who delivers, issues for delivery, or renews coverage in this state, including a group policy, contract, or certificate of health insurance or evidence of coverage delivered, issued for delivery, or renewed in this state by an insurer, including a group hospital service corporation operating under Chapter 842, or by a health maintenance organization operating under Chapter 843.

(5) "Test result" means a statement:

(A) that an identifiable individual is positive, negative, at risk, or has or does not have a certain level of antigen or antibody; or

(B) that indicates that an identifiable individual has or has not been tested for AIDS or HIV infection,

1 antibodies to HIV, or infection with any other probable causative
2 agent of AIDS. (V.T.I.C. Art. 21.21-4, Sec. (a); New.)

3 Sec. 545.002. EXCLUSIVE APPLICABILITY. This chapter and
4 rules adopted under this chapter exclusively govern the practices
5 of an issuer in testing applicants to determine or help determine if
6 an applicant has:

- 7 (1) AIDS or HIV infection;
8 (2) antibodies to HIV; or
9 (3) an infection with any other probable causative
10 agent of AIDS. (V.T.I.C. Art. 21.21-4, Sec. (p).)

11 Sec. 545.003. RULES. The commissioner may adopt:

- 12 (1) reasonable rules and forms necessary to implement
13 this chapter; and
14 (2) rules to be followed for an HIV-related test
15 requested or required by an issuer. (V.T.I.C. Art. 21.21-4, Sec.
16 (i).)

17 [Sections 545.004-545.050 reserved for expansion]

18 SUBCHAPTER B. ISSUER POWERS AND DUTIES

19 Sec. 545.051. HIV-RELATED TESTING AUTHORIZED. An issuer
20 may request or require an applicant to take an HIV-related test in
21 connection with the application. (V.T.I.C. Art. 21.21-4, Sec. (b)
22 (part).)

23 Sec. 545.052. NONDISCRIMINATORY BASIS REQUIRED. (a) An
24 issuer that requests or requires applicants to take an HIV-related
25 test must request or require the test on a nondiscriminatory basis.

26 (b) An issuer may require an applicant to take an
27 HIV-related test only if:

1 (1) the test is based on the applicant's current
2 medical condition or medical history; or

3 (2) underwriting guidelines for the coverage amounts
4 require all applicants in the risk class to be tested.

5 (c) In determining who will be requested or required to take
6 an HIV-related test, an issuer may not use the marital status,
7 occupation, sex, beneficiary designation, or territorial
8 classification, including zip code, of an applicant. (V.T.I.C.
9 Art. 21.21-4, Secs. (b) (part), (h).)

10 Sec. 545.053. EXPLANATION AND AUTHORIZATION REQUIRED. (a)
11 An issuer that requests or requires an applicant to take an
12 HIV-related test in connection with an application must:

13 (1) provide an explanation to the applicant, or
14 another person legally authorized to consent to the test, of how the
15 test will be used; and

16 (2) obtain a written authorization from the person to
17 whom the explanation is provided.

18 (b) The authorization must:

19 (1) be on a form adopted by the commissioner; and

20 (2) be separate from any other document presented to
21 the applicant or other person legally authorized to consent to the
22 test. (V.T.I.C. Art. 21.21-4, Sec. (c).)

23 Sec. 545.054. INQUIRIES REGARDING PREVIOUS TESTS. (a) An
24 issuer may inquire whether an applicant has:

25 (1) tested positive on an HIV-related test; or

26 (2) been diagnosed with HIV or AIDS.

27 (b) An issuer may not inquire whether an applicant has been

1 tested for or has received a negative result from a specific test
2 for:

- 3 (1) exposure to HIV; or
4 (2) a sickness or a medical condition derived from
5 infection with HIV. (V.T.I.C. Art. 21.21-4, Sec. (d).)

6 Sec. 545.055. NOTICE OF POSITIVE TEST RESULT; FEE. (a) An
7 applicant must be given written notice of a positive HIV-related
8 test result by:

- 9 (1) a physician designated by the applicant; or
10 (2) the Texas Department of Health, if the applicant
11 has not designated a physician.

12 (b) The Texas Department of Health by rule may set a fee, not
13 to exceed \$25, to cover the cost of giving written notice under this
14 section. (V.T.I.C. Art. 21.21-4, Sec. (f).)

15 Sec. 545.056. ADVERSE UNDERWRITING DECISION; TEST PROTOCOL
16 RULES. An issuer may not make an adverse underwriting decision
17 based on a positive HIV-related test unless a test protocol
18 established by commissioner rule is followed. (V.T.I.C. Art.
19 21.21-4, Sec. (g).)

20 Sec. 545.057. CONFIDENTIALITY OF TEST RESULT REQUIRED. (a)
21 An HIV-related test result is confidential.

22 (b) An issuer may not release or disclose the test result or
23 otherwise allow the test result to become known except as:

- 24 (1) required by law; or
25 (2) requested or authorized in writing by the
26 applicant or a person legally authorized to consent to the test on
27 the applicant's behalf.

1 (c) A test result released under Subsection (b)(2) may be
2 released only to:

3 (1) the applicant;

4 (2) a person legally authorized to consent to the
5 test;

6 (3) a licensed physician, medical practitioner, or
7 other person designated by the applicant;

8 (4) an insurance medical information exchange under
9 procedures designed to ensure confidentiality, including the use of
10 general codes that cover results of tests for other diseases or
11 conditions not related to AIDS, or for the preparation of
12 statistical reports that do not disclose the identity of any
13 particular applicant;

14 (5) a reinsurer, if the reinsurer is involved in the
15 underwriting process, under procedures designed to ensure
16 confidentiality;

17 (6) persons within the issuer's organization who have
18 the responsibility to make underwriting decisions for the issuer;
19 or

20 (7) outside legal counsel that needs the information
21 to effectively represent the issuer regarding the applicant.

22 (V.T.I.C. Art. 21.21-4, Sec. (e).)

23 [Sections 545.058-545.700 reserved for expansion]

24 SUBCHAPTER O. SANCTIONS; PENALTIES; INJUNCTIONS

25 Sec. 545.701. SANCTIONS. The commissioner may impose
26 sanctions under Chapter 82 on an issuer that violates this chapter.

27 (V.T.I.C. Art. 21.21-4, Sec. (q).)

1 Sec. 545.702. CIVIL ACTION; PENALTY. (a) A person who is
2 injured by a violation of Section 545.057 may bring a civil action
3 for damages.

4 (b) A person may bring an action to restrain a violation or
5 threatened violation of Section 545.057.

6 (c) If it is found in a civil action that a person or entity
7 has released or disclosed a test result or allowed a test result to
8 become known in violation of Section 545.057, the person or entity
9 is liable for:

10 (1) actual damages;

11 (2) a civil penalty of:

12 (A) not more than \$1,000 if the release or
13 disclosure was negligent; or

14 (B) not less than \$1,000 or more than \$5,000 if
15 the release or disclosure was wilful; and

16 (3) court costs and reasonable attorney's fees
17 incurred by the person bringing the action.

18 (d) A defendant in a civil action brought under this section
19 is not entitled to claim a privilege as a defense to the action.
20 (V.T.I.C. Art. 21.21-4, Secs. (j), (k), (l), (o).)

21 Sec. 545.703. CRIMINAL PENALTY. (a) A person or entity
22 commits an offense if the person or entity, with criminal
23 negligence, violates Section 545.057 by:

24 (1) releasing or disclosing a test result or other
25 information; or

26 (2) allowing a test result or other information to
27 become known.

(b) An offense under this section is a Class A misdemeanor.

(c) Each release or disclosure made or allowance of a test result to become known in violation of this chapter constitutes a separate offense. (V.T.I.C. Art. 21.21-4, Secs. (m), (n).)

CHAPTER 546. USE OF GENETIC TESTING INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 546.001. DEFINITIONS

Sec. 546.002. APPLICABILITY OF CHAPTER

Sec. 546.003. EXCEPTIONS

[Sections 546.004-546.050 reserved for expansion]

SUBCHAPTER B. GENETIC TESTING AND USE OF TEST RESULTS

Sec. 546.051. CERTAIN TESTING PERMITTED; INDUCEMENT

PROHIBITED

Sec. 546.052. IMPROPER USE OF TEST RESULTS; REFUSAL TO

SUBMIT TO TESTING

Sec. 546.053. TESTING RELATED TO PREGNANCY

Sec. 546.054. DESTRUCTION OF SAMPLE MATERIAL; EXCEPTIONS

[Sections 546.055-546.100 reserved for expansion]

SUBCHAPTER C. DISCLOSURE OF GENETIC INFORMATION;

CONFIDENTIALITY; EXCEPTIONS

Sec. 546.101. DISCLOSURE OF TEST RESULTS TO INDIVIDUAL

TESTED

Sec. 546.102. CONFIDENTIALITY OF GENETIC INFORMATION

Sec. 546.103. EXCEPTIONS TO CONFIDENTIALITY

Sec. 546.104. AUTHORIZED DISCLOSURE

[Sections 546.105-546.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT

1 Sec. 546.151. CEASE AND DESIST ORDER

2 Sec. 546.152. ADMINISTRATIVE PENALTY

3 CHAPTER 546. USE OF GENETIC TESTING INFORMATION

4 SUBCHAPTER A. GENERAL PROVISIONS

5 Sec. 546.001. DEFINITIONS. In this chapter:

6 (1) "DNA" means deoxyribonucleic acid.

7 (2) "Genetic characteristic" means a scientifically
8 or medically identifiable genetic or chromosomal variation,
9 composition, or alteration that predisposes an individual to a
10 disease, disorder, or syndrome.

11 (3) "Genetic information" means information that is:

12 (A) obtained from or based on a scientific or
13 medical determination of the presence or absence in an individual
14 of a genetic characteristic; or

15 (B) derived from the results of a genetic test
16 performed on an individual.

17 (4) "Genetic test" means a presymptomatic laboratory
18 test of an individual's genes, gene products, or chromosomes that:

19 (A) analyzes the individual's DNA, RNA,
20 proteins, or chromosomes; and

21 (B) is performed to identify any genetic
22 variation, composition, or alteration that is associated with the
23 individual's having a predisposition for:

24 (i) developing a clinically recognized
25 disease, disorder, or syndrome; or

26 (ii) being a carrier of a clinically
27 recognized disease, disorder, or syndrome.

1 The term does not include a blood test, cholesterol test,
2 urine test, or other physical test used for a purpose other than
3 determining a genetic or chromosomal variation, composition, or
4 alteration in a specific individual; a routine physical examination
5 or a routine test performed as part of a physical examination; a
6 test to determine drug use; or a test to determine the presence of
7 the human immunodeficiency virus.

8 (5) "RNA" means ribonucleic acid. (V.T.I.C. Art.
9 21.73, Secs. 1(1), (2), (3), (4), (6).)

10 Sec. 546.002. APPLICABILITY OF CHAPTER. This chapter
11 applies only to a group health benefit plan that:

12 (1) provides benefits for medical or surgical expenses
13 incurred as a result of a health condition, accident, or sickness,
14 including:

15 (A) a group, blanket, or franchise insurance
16 policy or insurance agreement, a group hospital service contract,
17 or a group evidence of coverage that is offered by:

18 (i) an insurance company;
19 (ii) a group hospital service corporation
20 operating under Chapter 842;

21 (iii) a fraternal benefit society operating
22 under Chapter 885;

23 (iv) a stipulated premium company operating
24 under Chapter 884; or

25 (v) a health maintenance organization
26 operating under Chapter 843; and

27 (B) to the extent permitted by the Employee

1 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
2 seq.), a group health benefit plan that is offered by:

3 (i) a multiple employer welfare arrangement
4 as defined by Section 3 of that Act;

5 (ii) another entity not authorized under
6 this code or another insurance law of this state that directly
7 contracts for health care services on a risk-sharing basis,
8 including a capitation basis; or

9 (iii) another analogous benefit
10 arrangement; or

11 (2) is offered by an approved nonprofit health
12 corporation that holds a certificate of authority under Chapter
13 844. (V.T.I.C. Art. 21.73, Sec. 2(a).)

14 Sec. 546.003. EXCEPTIONS. This chapter does not apply to:

15 (1) a plan that provides coverage:

16 (A) only for a specified disease;

17 (B) only for accidental death or dismemberment;

18 (C) for wages or payments in lieu of wages for a
19 period during which an employee is absent from work because of
20 sickness or injury; or

21 (D) as a supplement to liability insurance;

22 (2) a Medicare supplemental policy as defined by
23 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

24 (3) workers' compensation insurance coverage;

25 (4) medical payment insurance coverage provided under
26 a motor vehicle insurance policy; or

27 (5) a long-term care policy, including a nursing home

1 fixed indemnity policy, unless the commissioner determines that the
2 policy provides benefit coverage so comprehensive that the policy
3 is a group health benefit plan as described by Section 546.002.
4 (V.T.I.C. Art. 21.73, Sec. 2(b).)

5 [Sections 546.004-546.050 reserved for expansion]

6 SUBCHAPTER B. GENETIC TESTING AND USE OF TEST RESULTS

7 Sec. 546.051. CERTAIN TESTING PERMITTED; INDUCEMENT
8 PROHIBITED. (a) A group health benefit plan issuer that requests
9 an applicant for coverage under the plan to submit to a genetic test
10 in connection with the application for coverage for a purpose not
11 prohibited under Section 546.052 must:

- 12 (1) notify the applicant that the test is required;
13 (2) disclose to the applicant the proposed use of the
14 test results; and
15 (3) obtain the applicant's written informed consent
16 before the test is administered.

17 (b) The applicant shall state in the consent form whether
18 the applicant elects to be informed of the test results. If the
19 applicant elects to be informed, the person or entity that performs
20 the test shall disclose the test results to the applicant and the
21 group health benefit plan issuer. The issuer shall ensure that:

- 22 (1) the applicant receives an interpretation of the
23 test results made by a qualified health care practitioner; and
24 (2) a physician or other health care practitioner
25 designated by the applicant receives a copy of the test results.

26 (c) A group health benefit plan issuer may not use the
27 results of a genetic test conducted in accordance with Subsection

1 (a) to induce the purchase of coverage under the plan. (V.T.I.C.
2 Art. 21.73, Secs. 3(b), (c), (d).)

3 Sec. 546.052. IMPROPER USE OF TEST RESULTS; REFUSAL TO
4 SUBMIT TO TESTING. A group health benefit plan issuer may not use
5 genetic information or the refusal of an applicant to submit to a
6 genetic test to reject, deny, limit, cancel, refuse to renew,
7 increase the premiums for, or otherwise adversely affect
8 eligibility for or coverage under the plan. (V.T.I.C. Art. 21.73,
9 Secs. 3(a), (e).)

10 Sec. 546.053. TESTING RELATED TO PREGNANCY. (a) In this
11 section, "coerce" means to restrain or dominate a woman's free will
12 by actual or implied:

13 (1) force; or

14 (2) threat of rejecting, denying, limiting,
15 canceling, refusing to renew, or otherwise adversely affecting
16 eligibility for coverage under a group health benefit plan.

17 (b) A group health benefit plan issuer may not:

18 (1) require as a condition of coverage genetic testing
19 of a child in utero without the pregnant woman's consent; or

20 (2) use genetic information to coerce or compel a
21 pregnant woman to have an induced abortion. (V.T.I.C. Art. 21.73,
22 Sec. 8.)

23 Sec. 546.054. DESTRUCTION OF SAMPLE MATERIAL; EXCEPTIONS.
24 A sample of genetic material obtained from an individual for a
25 genetic test shall be destroyed promptly after the purpose for
26 which the sample was obtained is accomplished unless:

27 (1) the sample is retained under a court order;

1 (2) the individual authorizes retention of the sample
2 for medical treatment or scientific research;

3 (3) the sample was obtained for research that is
4 cleared by an institutional review board and retention of the
5 sample is:

6 (A) under a requirement the institutional review
7 board imposes on a specific research project; or

8 (B) authorized by the research participant with
9 institutional review board approval under federal law; or

10 (4) the sample was obtained for a screening test
11 established by the Texas Department of Health under Section 33.011,
12 Health and Safety Code, and performed by that department or a
13 laboratory approved by that department. (V.T.I.C. Art. 21.73, Sec.
14 6.)

15 [Sections 546.055-546.100 reserved for expansion]

16 SUBCHAPTER C. DISCLOSURE OF GENETIC INFORMATION;

17 CONFIDENTIALITY; EXCEPTIONS

18 Sec. 546.101. DISCLOSURE OF TEST RESULTS TO INDIVIDUAL
19 TESTED. (a) An individual who submits to a genetic test has the
20 right to know the results of the test. On the written request by the
21 individual, the group health benefit plan issuer or other entity
22 that performed the test shall disclose the test results to:

23 (1) the individual; or

24 (2) a physician designated by the individual.

25 (b) The right to receive information under this section is
26 in addition to any right or requirement established under Sections
27 546.051 and 546.052. (V.T.I.C. Art. 21.73, Sec. 5.)

1 Sec. 546.102. CONFIDENTIALITY OF GENETIC INFORMATION. (a)
2 Except as provided by Sections 546.103(a) and (b), genetic
3 information is confidential and privileged regardless of the source
4 of the information.

5 (b) A person or entity that holds genetic information about
6 an individual may not disclose or be compelled to disclose, by
7 subpoena or otherwise, that information unless the disclosure is
8 specifically authorized by the individual as provided by Section
9 546.104.

10 (c) This section applies to a redisclosure of genetic
11 information by a secondary recipient of the information after
12 disclosure of the information by an initial recipient. Except as
13 provided by Section 546.103(b), a group health benefit plan issuer
14 may not redisclose genetic information unless the redisclosure is
15 consistent with the disclosures authorized by the tested individual
16 under an authorization executed under Section 546.104. (V.T.I.C.
17 Art. 21.73, Secs. 4(a), (d) (part).)

18 Sec. 546.103. EXCEPTIONS TO CONFIDENTIALITY. (a) Subject
19 to Subchapter G, Chapter 411, Government Code, genetic information
20 may be disclosed without an authorization under Section 546.104 if
21 the disclosure is:

22 (1) authorized under a state or federal criminal law
23 relating to:

24 (A) the identification of individuals; or
25 (B) a criminal or juvenile proceeding, an
26 inquest, or a child fatality review by a multidisciplinary
27 child-abuse team;

1 (2) required under a specific order of a state or
2 federal court;

3 (3) for the purpose of establishing paternity as
4 authorized under a state or federal law;

5 (4) made to provide genetic information relating to a
6 decedent and the disclosure is made to the blood relatives of the
7 decedent for medical diagnosis; or

8 (5) made to identify a decedent.

9 (b) A group health benefit plan issuer may redisclose
10 genetic information without an authorization under Section
11 546.104:

12 (1) for actuarial or research studies if:

13 (A) a tested individual could not be identified
14 in any actuarial or research report; and

15 (B) any materials that identify a tested
16 individual are returned or destroyed as soon as reasonably
17 practicable;

18 (2) to the department for the purpose of enforcing
19 this chapter; or

20 (3) for a purpose directly related to enabling a
21 business decision to be made about:

22 (A) purchasing, transferring, merging, or
23 selling all or part of an insurance business; or

24 (B) obtaining reinsurance affecting that
25 insurance business.

26 (c) A redisclosure authorized under Subsection (b) may
27 contain only information reasonably necessary to accomplish the

1 purpose for which the information is disclosed. (V.T.I.C. Art.
2 21.73, Secs. 4(c), (d) (part), (e).)

3 Sec. 546.104. AUTHORIZED DISCLOSURE. An individual or an
4 individual's legal representative may authorize disclosure of
5 genetic information relating to the individual by an authorization
6 that:

7 (1) is written in plain language;

8 (2) is dated;

9 (3) contains a specific description of the information
10 to be disclosed;

11 (4) identifies or describes each person authorized to
12 disclose the genetic information to a group health benefit plan
13 issuer;

14 (5) identifies or describes the individuals or
15 entities to whom the disclosure or subsequent redisclosure of the
16 genetic information may be made;

17 (6) describes the specific purpose of the disclosure;

18 (7) is signed by the individual or legal
19 representative and, if the disclosure is made to claim proceeds of
20 an affected life insurance policy, the claimant; and

21 (8) advises the individual or legal representative
22 that the individual's authorized representative is entitled to
23 receive a copy of the authorization. (V.T.I.C. Art. 21.73, Sec.
24 4(b).)

25 [Sections 546.105-546.150 reserved for expansion]

26 SUBCHAPTER D. ENFORCEMENT

27 Sec. 546.151. CEASE AND DESIST ORDER. (a) On a finding by

1 the commissioner that a group health benefit plan issuer is in
2 violation of this chapter, the commissioner may issue a cease and
3 desist order in the manner provided by Chapter 83.

4 (b) If a group health benefit plan issuer refuses or fails
5 to comply with a cease and desist order issued under this section,
6 the commissioner may, in the manner provided by this code and other
7 insurance laws of this state, revoke or suspend the issuer's
8 certificate of authority or other authorization to operate a group
9 health benefit plan in this state. (V.T.I.C. Art. 21.73, Sec.
10 7(a).)

11 Sec. 546.152. ADMINISTRATIVE PENALTY. A group health
12 benefit plan issuer that operates a plan in violation of this
13 chapter is subject to an administrative penalty as provided by
14 Chapter 84. (V.T.I.C. Art. 21.73, Sec. 7(b).)

15 CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

16 SUBCHAPTER A. GENERAL PROVISIONS

17 Sec. 547.001. DEFINITIONS

18 Sec. 547.002. CONSTRUCTION OF CHAPTER

19 [Sections 547.003-547.050 reserved for expansion]

20 SUBCHAPTER B. PROHIBITION; ENFORCEMENT

21 Sec. 547.051. ACTS PROHIBITED

22 Sec. 547.052. NOTICE OF VIOLATION TO INSURER'S

23 DOMICILIARY STATE

24 Sec. 547.053. ENFORCEMENT ACTION

25 CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

26 SUBCHAPTER A. GENERAL PROVISIONS

27 Sec. 547.001. DEFINITIONS. In this chapter:

1 (1) "Alien or foreign insurer" means an insurance
2 company organized under the laws of:

- 3 (A) a country other than the United States; or
4 (B) a state of the United States other than this
5 state.

6 (2) "Resident" includes a domestic, alien, or foreign:
7 (A) corporation;
8 (B) partnership; or
9 (C) person. (V.T.I.C. Art. 21.21-1, Secs. 2(a),
10 (c).)

11 Sec. 547.002. CONSTRUCTION OF CHAPTER. This chapter shall
12 be construed liberally. (V.T.I.C. Art. 21.21-1, Sec. 1(b).)

13 [Sections 547.003-547.050 reserved for expansion]

14 SUBCHAPTER B. PROHIBITION; ENFORCEMENT

15 Sec. 547.051. ACTS PROHIBITED. (a) This section applies
16 only to an insurer's misrepresentation of:

- 17 (1) the insurer's financial condition;
18 (2) the terms of an existing or future contract;
19 (3) the benefits or advantages promised by an existing
20 or future contract; or
21 (4) the dividends or share of surplus to be received on
22 an existing or future contract.

23 (b) An unauthorized alien or foreign insurer may not:
24 (1) make, issue, circulate, or cause to be made,
25 issued, or circulated to a resident of this state a
26 misrepresentation in an advertisement, estimate, illustration,
27 circular, pamphlet, or letter that violates Chapter 541; or

1 (2) cause to be made to a resident of this state in a
2 newspaper, magazine, or other publication, or over a radio or
3 television station, a misrepresentation in an announcement or
4 statement that violates Chapter 541. (V.T.I.C. Art. 21.21-1, Sec.
5 3 (part).)

6 Sec. 547.052. NOTICE OF VIOLATION TO INSURER'S DOMICILIARY
7 STATE. (a) In this section, the domiciliary state of an alien
8 insurer is the state of entry or the state of the insurer's
9 principal office in the United States.

10 (b) If the department has reason to believe that an insurer
11 has engaged in an act prohibited by Section 547.051, the department
12 shall notify, by registered mail, the insurer and the insurance
13 supervisory official of the insurer's domiciliary state. (V.T.I.C.
14 Art. 21.21-1, Sec. 3 (part).)

15 Sec. 547.053. ENFORCEMENT ACTION. The department shall
16 take action under Chapter 541 against an insurer notified under
17 Section 547.052 if:

18 (1) after the 30th day following the date of notice,
19 the insurer has not stopped making, issuing, or circulating or
20 causing to be made, issued, or circulated in this state the false
21 misrepresentations; and

22 (2) the department has reason to believe that:

23 (A) the insurer is issuing or delivering
24 insurance contracts to residents of this state or is collecting
25 premiums on those contracts; and

26 (B) a department proceeding regarding the
27 misrepresentations is in the public interest. (V.T.I.C. Art.

21.21-1, Sec. 4.)

CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 548.001. PURPOSE

Sec. 548.002. DEFINITIONS

Sec. 548.003. RULEMAKING AUTHORITY

Sec. 548.004. RULES RELATING TO EQUITY SECURITIES AND

EXEMPT SECURITIES

[Sections 548.005-548.100 reserved for expansion]

SUBCHAPTER B. REQUIRED ACTS; PROHIBITIONS

Sec. 548.101. DEFINITION

Sec. 548.102. STATEMENT OF BENEFICIAL OWNERSHIP

OF EQUITY SECURITIES

Sec. 548.103. RECOVERY OF CERTAIN PROFITS

Sec. 548.104. SALE OR NONDELIVERY OF CERTAIN EQUITY

SECURITIES PROHIBITED

Sec. 548.105. CERTAIN SOLICITATIONS PROHIBITED; DISCLOSURE

BY INSURER

Sec. 548.106. NONAPPLICABILITY OF SUBCHAPTER

[Sections 548.107-548.200 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Sec. 548.201. OFFENSES; CRIMINAL PENALTY

Sec. 548.202. CIVIL PENALTY

Sec. 548.203. INJUNCTIVE ACTION

CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 548.001. PURPOSE. (a) The purpose of this chapter is

1 to provide for protection of the public interest, investors, and
2 shareholders of domestic stock insurers by:

3 (1) regulating proxy solicitation by domestic stock
4 insurers;

5 (2) regulating transactions by officers, directors,
6 and principal equity security holders of domestic stock insurers;
7 and

8 (3) requiring appropriate reporting of those
9 solicitations and transactions.

10 (b) To that end the misuse of information by certain
11 insiders of domestic stock insurers shall be prevented and a full
12 and fair disclosure of all material matters relevant to the
13 exercise of the corporate franchise of a shareholder of such an
14 insurer will be promoted and the free exercise of that franchise
15 will be assured.

16 (c) In exercising the authority granted by this chapter to
17 adopt rules, the commissioner shall promote the purposes of this
18 chapter to prevent misuse of information and to encourage good
19 faith dealing and full and fair disclosure. (V.T.I.C. Art. 21.48,
20 Sec. 13.)

21 Sec. 548.002. DEFINITIONS. In this chapter:

22 (1) "Domestic stock insurer" includes a domestic title
23 insurance company regulated by Title 11 and a stipulated premium
24 company regulated by Chapter 884.

25 (2) "Equity security" means:

26 (A) a stock or similar security;

27 (B) a security that:

1 (i) is convertible, with or without
2 consideration, into an equity security; or

3 (ii) carries a warrant or right to
4 subscribe to or purchase an equity security;

5 (C) a warrant or right to subscribe to or
6 purchase an equity security; or

7 (D) any other security defined as an equity
8 security in accordance with Section 548.004(a)(1).

9 (3) "Federal Securities Exchange Act" means the
10 Securities Exchange Act of 1934 (15 U.S.C. Section 77b et seq.), as
11 amended.

12 (4) "Officer" means:

13 (A) a president, vice president, treasurer,
14 actuary, secretary, or controller of a domestic stock insurer; or

15 (B) any other person who performs for a domestic
16 stock insurer the functions of an officer described by Paragraph
17 (A).

18 (5) "Person" means an individual, corporation,
19 partnership, association, joint-stock company, business trust, or
20 unincorporated organization. (V.T.I.C. Art. 21.48, Secs. 8(3), (4)
21 (part), (6), (7); New.)

22 Sec. 548.003. RULEMAKING AUTHORITY. The commissioner may:

23 (1) adopt rules necessary for the execution of the
24 powers and duties of the department or commissioner under this
25 subchapter and Subchapter B; and

26 (2) for that purpose classify domestic stock insurers,
27 securities, and other persons or matters under the jurisdiction of

1 the department or commissioner. (V.T.I.C. Art. 21.48, Sec. 10
2 (part).)

3 Sec. 548.004. RULES RELATING TO EQUITY SECURITIES AND
4 EXEMPT SECURITIES. (a) If the commissioner considers it necessary
5 or appropriate in the public interest or for the protection of
6 investors, the commissioner by rule may define:

7 (1) "equity security" to include a security that is
8 similar in nature to an equity security; and

9 (2) "exempt security" for purposes of this chapter.

10 (b) In adopting a rule under Subsection (a)(2), the
11 commissioner may define the term conditionally, on specified terms,
12 or for a stated period. (V.T.I.C. Art. 21.48, Secs. 8(4) (part),
13 (5).)

14 [Sections 548.005-548.100 reserved for expansion]

15 SUBCHAPTER B. REQUIRED ACTS; PROHIBITIONS

16 Sec. 548.101. DEFINITION. In this subchapter, "insider"
17 means a person who:

18 (1) is directly or indirectly the beneficial owner of
19 more than 10 percent of any class of an equity security of a
20 domestic stock insurer, other than an exempt security; or

21 (2) is a director or officer of a domestic stock
22 insurer. (V.T.I.C. Art. 21.48, Secs. 2 (part), 3 (part), 4 (part).)

23 Sec. 548.102. STATEMENT OF BENEFICIAL OWNERSHIP OF EQUITY
24 SECURITIES. (a) Not later than the 10th day after the date a person
25 becomes an insider, the insider shall file with the department a
26 statement of the amount of all equity securities of the insurer of
27 which the insider is a beneficial owner.

1 (b) If in any month a change occurs in the amount of the
2 equity securities of which the insider is a beneficial owner, the
3 insider shall file with the department not later than the 10th day
4 of the following month a statement that indicates:

5 (1) the amount of all equity securities of which the
6 insider is a beneficial owner as of the end of that month; and

7 (2) the changes in the insider's ownership that
8 occurred in that month.

9 (c) A statement under this section must be in the form
10 prescribed by the department. (V.T.I.C. Art. 21.48, Sec. 2
11 (part).)

12 Sec. 548.103. RECOVERY OF CERTAIN PROFITS. (a) The purpose
13 of this section is to prevent the unfair use of information that may
14 be obtained by an insider because of the insider's relationship
15 with the domestic stock insurer.

16 (b) Any profit realized by the insider from the purchase and
17 sale or from the sale and purchase of an equity security of the
18 domestic stock insurer within a period of less than six months
19 inures to and is recoverable by the insurer.

20 (c) A suit to recover the profit must be brought not later
21 than the second anniversary of the date the profit is realized. The
22 suit may be instituted at law or in equity by:

23 (1) the domestic stock insurer; or

24 (2) the owner of any security of the domestic stock
25 insurer, in the name of and in behalf of the insurer, if the insurer
26 does not:

27 (A) bring suit not later than the 60th day after

1 the date a request is made; or

2 (B) diligently prosecute a suit that is timely
3 brought by the insurer.

4 (d) Subsection (b) applies regardless of whether:

5 (1) the insider intended to hold the equity security
6 purchased for longer than six months; or

7 (2) the insider did not intend to repurchase the sold
8 equity security during the six-month period following the date the
9 insider sold the equity security.

10 (e) Subsection (b) does not apply to:

11 (1) a transaction in which an equity security was
12 acquired in good faith in connection with a previously contracted
13 debt;

14 (2) a transaction in which the beneficial owner of an
15 equity security was not the beneficial owner at both the time of the
16 purchase and the time of the sale, or the sale and purchase, of the
17 security involved;

18 (3) a transaction involving an exempt security;

19 (4) a transaction that the commissioner by rule
20 exempts from this section because it is beyond the scope of the
21 purpose of this section; or

22 (5) a transaction involving an equity security of a
23 domestic stock insurer that is not held by a dealer in an investment
24 account if the transaction:

25 (A) is in the ordinary course of the dealer's
26 business; and

27 (B) is incident to the establishment or

1 maintenance by the dealer of a primary or secondary market, other
2 than on an exchange, as defined by the federal Securities Exchange
3 Act, for the security.

4 (f) The commissioner may adopt rules the commissioner
5 considers necessary or appropriate in the public interest to define
6 and prescribe terms and conditions with respect to a security held
7 in an investment account and a transaction made in the ordinary
8 course of business and incident to the establishment or maintenance
9 of a primary or secondary market. (V.T.I.C. Art. 21.48, Secs. 3, 6
10 (part).)

11 Sec. 548.104. SALE OR NONDELIVERY OF CERTAIN EQUITY
12 SECURITIES PROHIBITED. (a) An insider may not directly or
13 indirectly sell an equity security of the domestic stock insurer if
14 the insider selling the security or the insider's principal:

15 (1) does not own the security; or

16 (2) owns the security, but does not:

17 (A) deliver the security before the 21st day
18 after the date of the sale; or

19 (B) deposit the security in the mail or another
20 usual channel of transportation before the sixth day after the date
21 of the sale.

22 (b) An insider is not considered to have violated Subsection
23 (a)(2) if the insider proves that:

24 (1) notwithstanding the exercise of good faith, the
25 insider was unable to make a timely delivery or deposit; or

26 (2) to make a timely delivery or deposit would cause
27 undue inconvenience or expense.

1 (c) Subsection (a) does not apply to the sale of:

2 (1) an exempt security; or

3 (2) an equity security of a domestic stock insurer
4 that is not held by a dealer in an investment account if the sale:

5 (A) is in the ordinary course of the dealer's
6 business; and

7 (B) is incident to the establishment or
8 maintenance by the dealer of a primary or secondary market, other
9 than on an exchange, as defined by the federal Securities Exchange
10 Act, for the security.

11 (d) The commissioner may adopt rules implementing
12 Subsection (c) in the manner prescribed by Section 548.103(f).
13 (V.T.I.C. Art. 21.48, Secs. 4, 6 (part).)

14 Sec. 548.105. CERTAIN SOLICITATIONS PROHIBITED; DISCLOSURE
15 BY INSURER. (a) A person, in violation of any rule adopted by the
16 commissioner under this section, may not solicit or permit the use
17 of the person's name to solicit a proxy, consent, or authorization
18 with respect to an equity security, other than an exempt security,
19 of a domestic stock insurer that is not listed on a national
20 securities exchange registered as such under the federal Securities
21 Exchange Act.

22 (b) Unless before an annual or other meeting a proxy,
23 consent, or authorization with respect to a security of a domestic
24 stock insurer covered by Subsection (a) is solicited by or on behalf
25 of the management of the insurer from a holder of record of the
26 security in compliance with rules adopted by the commissioner under
27 this section, the insurer shall, in accordance with rules adopted

1 by the commissioner, file with the department information
2 substantially equivalent to the information that would be required
3 to be sent if a solicitation were made. The insurer shall send the
4 information to each holder of record of the security.

5 (c) The commissioner may adopt rules to implement this
6 section that the commissioner considers necessary or appropriate in
7 the public interest or for the protection of investors. (V.T.I.C.
8 Art. 21.48, Sec. 5.)

9 Sec. 548.106. NONAPPLICABILITY OF SUBCHAPTER. (a) This
10 subchapter does not apply to an equity security of a domestic stock
11 insurer if:

12 (1) the security is or is required to be registered
13 under Section 12 of the federal Securities Exchange Act; or

14 (2) the insurer does not have any class of its equity
15 securities held of record by 100 or more persons on the last
16 business day of the year preceding the year in which the equity
17 security would otherwise be subject to this subchapter.

18 (b) Sections 548.101-548.104 do not apply to a foreign or
19 domestic arbitrage transaction unless the transaction is made in
20 violation of a rule adopted by the commissioner to accomplish the
21 purposes of this chapter.

22 (c) A provision of this subchapter that imposes liability
23 does not apply to an act or omission made in good faith in
24 conformity with a rule adopted by the commissioner. This
25 subsection applies regardless of whether the rule is subsequently
26 amended, rescinded, or determined by judicial or other authority to
27 be invalid for any reason. (V.T.I.C. Art. 21.48, Secs. 7, 9, 10

(part).)

[Sections 548.107-548.200 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Sec. 548.201. OFFENSES; CRIMINAL PENALTY. (a) A person commits an offense if the person intentionally:

(1) violates this chapter or a rule adopted under this chapter; or

(2) makes or causes to be made a statement that is false or misleading with respect to a material fact in a document required to be filed by this chapter or a rule adopted under this chapter.

(b) Except as provided by Subsection (c), an offense under this section is punishable by:

(1) a fine not to exceed \$10,000;

(2) imprisonment for not more than two years; or

(3) both the fine and imprisonment.

(c) A person may not be punished by imprisonment for violating a rule as prescribed by this section if the person proves that the person had no knowledge of the rule. (V.T.I.C. Art. 21.48, Sec. 11.)

Sec. 548.202. CIVIL PENALTY. (a) A person who wilfully violates this chapter or a rule adopted under this chapter is liable for a civil penalty of not less than \$100 or more than \$1,000 for:

(1) each act of violation; and

(2) each day of violation.

(b) The attorney general, at the request of the commissioner, shall bring a suit in the name of the state to recover

the civil penalty. The suit must be brought:

(1) in Travis County or the county in which the person resides;

(2) if more than one person commits the violation, in the county in which any of the persons resides; or

(3) in the county in which the violation allegedly occurred. (V.T.I.C. Art. 21.48, Sec. 12 (part).)

Sec. 548.203. INJUNCTIVE ACTION. A suit to enjoin a violation or a threatened violation of this chapter may be brought in any district court in which an action for a civil penalty under Section 548.202 may be brought. (V.T.I.C. Art. 21.48, Sec. 12 (part).)

CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 549.001. DEFINITIONS

Sec. 549.002. INAPPLICABILITY OF CHAPTER TO TITLE
INSURANCE

Sec. 549.003. CANCELLATION OF POLICY AFTER FORECLOSURE
AUTHORIZED

[Sections 549.004-549.050 reserved for expansion]

SUBCHAPTER B. PROHIBITED PRACTICES

Sec. 549.051. FEES FOR SUBSTITUTION OR REPLACEMENT OF
POLICY

Sec. 549.052. REQUIRING POLICY FROM PARTICULAR SOURCE

Sec. 549.053. USE OF POLICY INFORMATION

Sec. 549.054. REQUIRING EVIDENCE OF INSURANCE BEFORE

1 TERMINATION OF POLICY

2 Sec. 549.055. INSURANCE BINDER AS EVIDENCE OF
3 INSURANCE

4 Sec. 549.056. CERTAIN ACTIONS BY LENDER NOT
5 PROHIBITED

6 [Sections 549.057-549.100 reserved for expansion]

7 SUBCHAPTER C. ENFORCEMENT AND CIVIL REMEDIES

8 Sec. 549.101. ENFORCEMENT ACTION

9 Sec. 549.102. CIVIL DAMAGES

10 CHAPTER 549. PROHIBITED PRACTICES RELATING TO
11 PROPERTY INSURANCE

12 SUBCHAPTER A. GENERAL PROVISIONS

13 Sec. 549.001. DEFINITIONS. In this chapter:

14 (1) "Borrower" means an individual, partnership,
15 corporation, association, or other entity who has or acquires a
16 legal or equitable interest in real or personal property that is or
17 becomes subject to a mortgage, lien, security agreement, deed of
18 trust, or other security instrument.

19 (2) "Insurance binder" means a contract that provides
20 insurance coverage pending the issuance of an original insurance
21 policy that will be issued on or before the 30th day after the date
22 the insurance binder is issued.

23 (3) "Lender" means an individual, partnership,
24 corporation, association, or other entity, agent, loan agent,
25 servicing agent, or loan or mortgage broker who lends money and
26 receives or otherwise acquires a mortgage, a lien, a deed of trust,
27 or any other security interest in or on any real or personal

1 property as security for the loan. (V.T.I.C. Art. 21.48A, Sec. 1.)

2 Sec. 549.002. INAPPLICABILITY OF CHAPTER TO TITLE
3 INSURANCE. This chapter does not apply to title insurance.
4 (V.T.I.C. Art. 21.48A, Sec. 5.)

5 Sec. 549.003. CANCELLATION OF POLICY AFTER FORECLOSURE
6 AUTHORIZED. In the event of a foreclosure under a deed of trust,
7 the lender may cancel an insurance policy covering the foreclosed
8 property and is entitled to any unearned premiums from the policy if
9 the lender:

10 (1) credits the amount of the unearned premiums
11 against any deficiency owed by the borrower; and

12 (2) delivers to the borrower any excess unearned
13 premiums not credited against a deficiency under Subdivision (1).
14 (V.T.I.C. Art. 21.48A, Sec. 3A.)

15 [Sections 549.004-549.050 reserved for expansion]

16 SUBCHAPTER B. PROHIBITED PRACTICES

17 Sec. 549.051. FEES FOR SUBSTITUTION OR REPLACEMENT OF
18 POLICY. (a) A lender may not require a fee in an amount greater
19 than \$10 for the substitution by the borrower of a new insurance
20 policy for another insurance policy in effect, or require a fee for
21 the furnishing by the borrower of a new insurance policy to replace
22 an existing insurance policy on termination of the existing policy,
23 if the new insurance policy is provided through an insurer
24 authorized to engage in business in this state.

25 (b) On the sale or transfer of the lender's ownership
26 interest in real or personal property, the lender is subject to the
27 payment of a substitution fee as described by Subsection (a) and may

1 not, directly or indirectly, charge the borrower for the
2 substitution fee. (V.T.I.C. Art. 21.48A, Secs. 2(a), (e).)

3 Sec. 549.052. REQUIRING POLICY FROM PARTICULAR SOURCE. A
4 lender may not directly or indirectly require as a condition of the
5 financing or lending of money or the renewal or extension of
6 financing or lending of money that the purchaser or borrower or the
7 successors of the purchaser or borrower obtain an insurance policy
8 or the renewal or extension of an insurance policy covering the
9 property involved in the transaction from or through:

10 (1) a particular agent, insurer, or other person; or

11 (2) a particular type or class of agent, insurer, or
12 other person. (V.T.I.C. Art. 21.48A, Sec. 2(b).)

13 Sec. 549.053. USE OF POLICY INFORMATION. (a) Except as
14 otherwise provided by this section, a lender may not:

15 (1) use or permit the use of any information taken from
16 an insurance policy insuring the borrower's property for the
17 purpose of soliciting insurance business from the borrower; or

18 (2) make information taken from an insurance policy
19 insuring the borrower's property available to any other person for
20 any purpose.

21 (b) Subsection (a) does not:

22 (1) apply if the borrower provides the lender with
23 specific written authority permitting or directing the particular
24 use or disclosure of information before the use or disclosure
25 occurs; or

26 (2) prevent a lender who is a licensed general
27 property and casualty agent from selling insurance to a borrower.

1 (V.T.I.C. Art. 21.48A, Sec. 2(c).)

2 Sec. 549.054. REQUIRING EVIDENCE OF INSURANCE BEFORE
3 TERMINATION OF POLICY. A lender may not require a borrower to
4 provide evidence of insurance earlier than the 15th day before the
5 termination date of an existing insurance policy. (V.T.I.C. Art.
6 21.48A, Sec. 2(d).)

7 Sec. 549.055. INSURANCE BINDER AS EVIDENCE OF INSURANCE.

8 (a) A lender that requires a borrower to secure insurance coverage
9 before the lender will provide a residential mortgage or commercial
10 real estate loan must accept an insurance binder as evidence of the
11 required insurance and may not require the borrower to provide an
12 original insurance policy instead of a binder if:

13 (1) the binder is issued by a licensed general
14 property and casualty agent who is appointed to represent the
15 insurer whose name appears on the binder and who is authorized to
16 issue binders;

17 (2) the binder is accompanied by evidence of payment
18 of the required premium; and

19 (3) the binder will be replaced by an original
20 insurance policy for the required coverage on or before the 30th day
21 after the date the binder is issued.

22 (b) A general property and casualty agent who issues an
23 insurance binder under Subsection (a) must, on request, provide the
24 lender with appropriate evidence for purposes of Subsection (a)(1).
25 (V.T.I.C. Art. 21.48A, Sec. 2(f).)

26 Sec. 549.056. CERTAIN ACTIONS BY LENDER NOT PROHIBITED.

27 (a) This subchapter does not prevent a lender from requiring

1 evidence to be produced before the commencement or renewal of a risk
2 that insurance has been obtained that:

- 3 (1) has a fixed termination date;
4 (2) provides adequate coverage in an amount sufficient
5 to cover the debt or loan; and
6 (3) will not be canceled without reasonable notice to
7 the lender.

8 (b) This subchapter does not prevent a lender from requiring
9 insurance from an insurer that is authorized to engage in business
10 in this state and that has a licensed resident agent in this state.

11 (c) This subchapter does not prevent a lender from refusing
12 to accept or approve insurance from a particular insurer on
13 reasonable and nondiscriminatory grounds relating to the financial
14 soundness of the insurer or the insurer's ability to service the
15 policy.

16 (d) This subchapter does not prevent a lender from
17 providing, in accordance with the terms of the mortgage, security
18 agreement, deed of trust, or other security instrument, insurance
19 coverage adequate to protect the lender's security interest in
20 property in the event the borrower fails to provide on or before the
21 15th day before the termination date of an existing insurance
22 policy an insurance policy meeting the requirements established by
23 the lender as authorized by this chapter. A lender that provides
24 insurance coverage under this subsection may use information
25 contained in the existing policy for the purpose of determining
26 that the insurance coverage provided is adequate.

27 (e) Except as provided by this subsection, this subchapter

1 does not prevent a lender from requiring at or before the time of
2 delivery by a general property and casualty agent or insurer of an
3 insurance policy to the lender a written statement from the
4 borrower designating the agent or insurer as the borrower's agent
5 for the delivery of the policy. A lender may not require a
6 statement described by this subsection when an agent or insurer is
7 providing a renewal of an existing expiring insurance policy
8 provided by the agent or insurer.

9 (f) This subchapter does not prevent a lender from providing
10 to a person, firm, or corporation that is or becomes the owner or
11 holder of a note or obligation secured by a mortgage, security
12 agreement, deed of trust, or other security instrument an insurance
13 policy or any information contained in an insurance policy that
14 covers property that is security for the loan.

15 (g) This subchapter does not prevent a lender from
16 processing a claim under the terms of an insurance policy that
17 covers property that is security for a loan. (V.T.I.C. Art. 21.48A,
18 Sec. 3.)

19 [Sections 549.057-549.100 reserved for expansion]

20 SUBCHAPTER C. ENFORCEMENT AND CIVIL REMEDIES

21 Sec. 549.101. ENFORCEMENT ACTION. The attorney general,
22 commissioner, or department may institute a proceeding to enforce
23 this chapter and to enjoin any individual, partnership,
24 corporation, association, or other entity from engaging or
25 attempting to engage in any activity in violation of this chapter.
26 (V.T.I.C. Art. 21.48A, Sec. 4(a) (part).)

27 Sec. 549.102. CIVIL DAMAGES. (a) A borrower may recover

1 from a lender who violates this chapter civil damages in an amount
2 equal to three times the annual premium for the insurance policy in
3 force on the property that is security for the loan.

4 (b) If the insurance policy is for a period of more than one
5 year, the annual premium is computed by dividing the total premium
6 specified in the policy for the entire period of the policy by the
7 number of years of the duration of the policy. (V.T.I.C. Art.
8 21.48A, Sec. 4(b).)

9 CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

10 Sec. 550.001. SOLICITATION OR COLLECTION

11 OF CERTAIN PAYMENTS

12 Sec. 550.002. INCREASE IN CERTAIN

13 PREMIUM PAYMENTS

14 CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

15 Sec. 550.001. SOLICITATION OR COLLECTION OF CERTAIN
16 PAYMENTS. (a) An insurer or an insurer's agent or sponsoring
17 organization may not solicit or collect, in connection with an
18 application for insurance or the issuance of a policy, a payment
19 other than:

- 20 (1) a premium;
- 21 (2) a tax;
- 22 (3) a finance charge;
- 23 (4) a policy fee;
- 24 (5) an agent fee;
- 25 (6) a service fee, including a charge for costs
- 26 described by Section 4005.003;
- 27 (7) an inspection fee; or

1 (8) membership dues in a sponsoring organization.

2 (b) The commissioner by rule shall permit a sponsoring
3 organization to solicit a voluntary contribution with a membership
4 renewal solicitation if the membership renewal solicitation is
5 separate from an insurance billing.

6 (c) Except as otherwise provided by statute, an insurer may
7 require that membership dues in its sponsoring organization be paid
8 as a condition for issuance or renewal of an insurance policy.

9 (d) Criminal penalties for a violation of this section are
10 the same as criminal penalties provided for a violation under
11 Subchapter K, Chapter 823. (V.T.I.C. Art. 21.35B.)

12 Sec. 550.002. INCREASE IN CERTAIN PREMIUM PAYMENTS. (a) In
13 this section:

14 (1) "Account" means a person's account in a financial
15 institution.

16 (2) "Financial institution" means a state or national
17 bank, a state or federal savings and loan association or
18 corporation, or a state or federal credit union.

19 (3) "Insurer" means a person or entity engaged in the
20 business of insurance in this state as described by Chapter 101.
21 The term includes a person or entity engaged in the business of
22 surplus lines insurance in this state.

23 (4) "Person" means an insured, a policy or certificate
24 holder, or an owner of an insurance policy or certificate.

25 (b) An insurer receiving automatic premium payments through
26 withdrawal of funds from a person's account, including an escrow
27 account, as authorized by that person to pay premiums on insurance

1 coverage provided through that insurer, may not increase the amount
2 of funds to be withdrawn from the account to pay premiums on that
3 coverage unless:

4 (1) the insurer, not later than the 30th day before the
5 effective date of the increase in the premium payment amount,
6 notifies the person of the increase and provides the person a
7 postage prepaid form that may be used to object to the increase; and

8 (2) neither the insurer nor the financial institution
9 receives written objection to the increase on or before the fifth
10 day before the date on which the increase takes effect.

11 (c) This section does not require an insurer to notify a
12 person of an increase in a premium payment amount if:

13 (1) the insurance contract or certificate:

14 (A) when issued contains a schedule of increasing
15 premiums;

16 (B) expressly specifies the exact amount of each
17 premium; and

18 (C) specifies the period for which each premium
19 is payable; or

20 (2) the increase is the result of a change ordered by
21 the insured.

22 (d) This section does not apply to an increase in a premium
23 payment that is less than \$10 or 10 percent of the previous amount
24 per month. (V.T.I.C. Art. 21.57.)

25 CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION,

26 CANCELLATION, AND NONRENEWAL OF INSURANCE POLICIES

27 SUBCHAPTER A. GENERAL REQUIREMENTS

1 Sec. 551.001. RULES

2 Sec. 551.002. WRITTEN STATEMENT OF REASONS FOR DECLINATION,
3 CANCELLATION, OR NONRENEWAL

4 Sec. 551.003. IMMUNITY FROM LIABILITY

5 [Sections 551.004-551.050 reserved for expansion]

6 SUBCHAPTER B. CANCELLATION AND NONRENEWAL OF
7 CERTAIN LIABILITY INSURANCE POLICIES

8 Sec. 551.051. DEFINITIONS

9 Sec. 551.052. CANCELLATION PROHIBITED; EXCEPTIONS

10 Sec. 551.053. WRITTEN NOTICE OF CANCELLATION REQUIRED

11 Sec. 551.054. WRITTEN NOTICE OF NONRENEWAL REQUIRED

12 Sec. 551.055. REASON FOR CANCELLATION OR NONRENEWAL
13 REQUIRED

14 Sec. 551.056. TRANSFER NOT CONSIDERED REFUSAL
15 TO RENEW

16 [Sections 551.057-551.100 reserved for expansion]

17 SUBCHAPTER C. CANCELLATION AND NONRENEWAL OF
18 CERTAIN PROPERTY AND CASUALTY POLICIES

19 Sec. 551.101. DEFINITION

20 Sec. 551.102. APPLICABILITY OF SUBCHAPTER

21 Sec. 551.103. CANCELLATION

22 Sec. 551.104. AUTHORIZED CANCELLATION OF POLICIES

23 Sec. 551.105. NONRENEWAL OF POLICIES; NOTICE REQUIRED

24 Sec. 551.106. RENEWAL OF PERSONAL AUTOMOBILE INSURANCE
25 POLICIES

26 Sec. 551.107. RENEWAL OF CERTAIN POLICIES; PREMIUM SURCHARGE
27 AUTHORIZED; NOTICE

1 Sec. 551.108. INSURER RECORDS

2 Sec. 551.109. INSURER STATEMENT

3 Sec. 551.110. LIABILITY FOR DISCLOSURE

4 Sec. 551.111. EFFECT OF NONCOMPLIANCE

5 Sec. 551.112. RULES

6 [Sections 551.113-551.150 reserved for expansion]

7 SUBCHAPTER D. CANCELLATION OR NONRENEWAL OF

8 CERTAIN POLICIES ISSUED TO ELECTED OFFICIALS

9 Sec. 551.151. DEFINITION

10 Sec. 551.152. ELECTED OFFICIALS

11 CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION,

12 CANCELLATION, AND NONRENEWAL OF INSURANCE POLICIES

13 SUBCHAPTER A. GENERAL REQUIREMENTS

14 Sec. 551.001. RULES. (a) The commissioner may, as
15 necessary, adopt and enforce reasonable rules, including notice
16 requirements, relating to the cancellation and nonrenewal of any
17 insurance policy regulated by the department under Chapter 5, other
18 than:

19 (1) a policy subject to Subchapter B or C; or

20 (2) a marine insurance policy other than inland
21 marine.

22 (b) In adopting rules under this section, the commissioner
23 shall consider the reasonable needs of the public and the
24 operations of the insurers. (V.T.I.C. Art. 21.49-2 (part).)

25 Sec. 551.002. WRITTEN STATEMENT OF REASONS FOR DECLINATION,
26 CANCELLATION, OR NONRENEWAL. (a) The commissioner shall require
27 an insurer, on request by an applicant for insurance or a

1 policyholder, to provide to the applicant or policyholder a written
2 statement of the reasons for the declination, cancellation, or
3 nonrenewal of an insurance policy to which Section 551.001 applies.

4 (b) An insurer's written statement giving the reasons for
5 the declination, cancellation, or nonrenewal of an insurance policy
6 must fully explain a decision that adversely affects an applicant
7 for insurance or a policyholder by denying the applicant or
8 policyholder insurance coverage or continued coverage.

9 (c) The statement must:

10 (1) state the precise incident, circumstance, or risk
11 factors applicable to the applicant for insurance or the
12 policyholder that violates any applicable guidelines;

13 (2) state the source of information on which the
14 insurer relied regarding the incident, circumstance, or risk
15 factors; and

16 (3) specify any other information considered relevant
17 by the commissioner.

18 (d) The commissioner shall adopt rules as necessary to
19 implement this section. (V.T.I.C. Art. 21.49-2 (part); Art.
20 21.49-2E, Secs. (a) (part), (b).)

21 Sec. 551.003. IMMUNITY FROM LIABILITY. An insurer or agent
22 or an employee of an insurer or agent is not liable, and a cause of
23 action does not arise against that individual or entity, for a
24 statement, disclosure, or communication made in good faith under
25 this subchapter. Immunity under this section does not apply to:

26 (1) disclosure of information known to be false; or

27 (2) a disclosure made with malice or the wilful intent

1 to injure any person. (V.T.I.C. Art. 21.49-2 (part).)

2 [Sections 551.004-551.050 reserved for expansion]

3 SUBCHAPTER B. CANCELLATION AND NONRENEWAL OF
4 CERTAIN LIABILITY INSURANCE POLICIES

5 Sec. 551.051. DEFINITIONS. In this subchapter:

6 (1) "Insurer" means an insurance company or other
7 entity admitted to engage in business and authorized to write
8 liability insurance in this state, including a county mutual
9 insurance company, a Lloyd's plan, and a reciprocal or
10 interinsurance exchange. The term does not include a county mutual
11 fire insurance company that writes exclusively industrial fire
12 insurance as described by Section 912.310 or a farm mutual
13 insurance company.

14 (2) "Liability insurance" means:

15 (A) general liability insurance;

16 (B) professional liability insurance other than
17 medical professional liability insurance;

18 (C) commercial automobile liability insurance;

19 (D) commercial multiperil insurance; and

20 (E) any other type or line of liability insurance
21 designated by the department. (V.T.I.C. Art. 21.49-2A, Sec. (a).)

22 Sec. 551.052. CANCELLATION PROHIBITED; EXCEPTIONS. (a) An
23 insurer may not cancel a liability insurance policy that is a
24 renewal or continuation policy.

25 (b) An insurer may not cancel a liability insurance policy
26 during the initial policy term after the 60th day following the date
27 on which the policy was issued.

1 (c) Notwithstanding Subsections (a) and (b), an insurer may
2 cancel a liability insurance policy at any time during the term of
3 the policy for:

- 4 (1) fraud in obtaining coverage;
5 (2) failure to pay premiums when due;
6 (3) an increase in hazard within the control of the
7 insured that would produce a rate increase; or
8 (4) loss of the insurer's reinsurance covering all or
9 part of the risk covered by the policy.

10 (d) Notwithstanding Subsections (a) and (b), an insurer may
11 cancel a liability insurance policy at any time during the term of
12 the policy if the insurer is placed in supervision,
13 conservatorship, or receivership and the cancellation or
14 nonrenewal is approved or directed by the supervisor, conservator,
15 or receiver. (V.T.I.C. Art. 21.49-2A, Secs. (b), (c).)

16 Sec. 551.053. WRITTEN NOTICE OF CANCELLATION REQUIRED. Not
17 later than the 10th day before the date on which the cancellation of
18 a liability insurance policy takes effect, an insurer must deliver
19 or mail written notice of the cancellation to the first-named
20 insured under the policy at the address shown on the policy.
21 (V.T.I.C. Art. 21.49-2A, Sec. (d).)

22 Sec. 551.054. WRITTEN NOTICE OF NONRENEWAL REQUIRED. (a)
23 An insurer may refuse to renew a liability insurance policy if the
24 insurer delivers or mails written notice of the nonrenewal to the
25 first-named insured under the policy at the address shown on the
26 policy.

27 (b) The notice must be delivered or mailed not later than

1 the 60th day before the date on which the policy expires. If the
2 notice is delivered or mailed later than the 60th day before the
3 date on which the policy expires, the coverage remains in effect
4 until the 61st day after the date on which the notice is delivered
5 or mailed.

6 (c) Earned premium for any period of coverage that extends
7 beyond the expiration date of the policy shall be computed pro rata
8 based on the previous year's rate. (V.T.I.C. Art. 21.49-2A, Sec.
9 (e).)

10 Sec. 551.055. REASON FOR CANCELLATION OR NONRENEWAL
11 REQUIRED. In a notice to an insured relating to cancellation or
12 refusal to renew, an insurer must state the reason for the
13 cancellation or nonrenewal. The statement must comply with:

14 (1) Sections 551.002(b) and (c); and

15 (2) rules adopted under Section 551.002(d). (V.T.I.C.
16 Art. 21.49-2A, Sec. (g); Art. 21.49-2E, Sec. (a) (part).)

17 Sec. 551.056. TRANSFER NOT CONSIDERED REFUSAL TO RENEW.
18 For purposes of this subchapter, the transfer of a policyholder
19 between admitted companies within the same insurance group is not
20 considered a refusal to renew. (V.T.I.C. Art. 21.49-2A, Sec. (f).)

21 [Sections 551.057-551.100 reserved for expansion]

22 SUBCHAPTER C. CANCELLATION AND NONRENEWAL OF
23 CERTAIN PROPERTY AND CASUALTY POLICIES

24 Sec. 551.101. DEFINITION. In this subchapter, "insurer"
25 means any authorized insurer writing property and casualty
26 insurance in this state, including:

27 (1) a county mutual insurance company;

- 1 (2) a Lloyd's plan;
- 2 (3) a reciprocal or interinsurance exchange; and
- 3 (4) a farm mutual insurance company. (V.T.I.C. Art.
- 4 21.49-2B, Sec. 1(1).)

5 Sec. 551.102. APPLICABILITY OF SUBCHAPTER. This subchapter

6 applies only to:

7 (1) a personal automobile insurance policy, other than

8 a policy written through the Texas Automobile Insurance Plan

9 Association;

10 (2) a homeowners or farm or ranch owners insurance

11 policy;

12 (3) a standard fire insurance policy insuring:

13 (A) a one-family dwelling or a duplex; or

14 (B) the contents of a one-family dwelling, a

15 duplex, or an apartment; or

16 (4) an insurance policy providing property and

17 casualty coverage, other than a fidelity, surety, or guaranty bond,

18 to:

19 (A) this state;

20 (B) an agency of this state;

21 (C) a political subdivision of this state,

22 including:

23 (i) a municipality or county;

24 (ii) a school district or junior college

25 district;

26 (iii) a levee improvement district,

27 drainage district, or irrigation district;

(iv) a water improvement district, water control and improvement district, or water control and preservation district;

(v) a freshwater supply district;

(vi) a navigation district;

(vii) a conservation and reclamation district;

(viii) a soil conservation district;

(ix) a communication district; and

(x) a river authority; or

(D) any other governmental agency whose authority is derived from the laws or constitution of this state. (V.T.I.C. Art. 21.49-2B, Secs. 1(2), 2.)

Sec. 551.103. CANCELLATION. For the purposes of this subchapter, an insurer has canceled an insurance policy if the insurer, without the consent of the insured:

(1) terminates coverage provided under the policy;

(2) refuses to provide additional coverage to which the insured is entitled under the policy; or

(3) reduces or restricts coverage under the policy by endorsement or other means. (V.T.I.C. Art. 21.49-2B, Sec. 3.)

Sec. 551.104. AUTHORIZED CANCELLATION OF POLICIES. (a) An insurer may cancel an insurance policy only as provided by this section.

(b) An insurer may cancel any policy if:

(1) the named insured does not pay any portion of the premium when due;

1 (2) the insured submits a fraudulent claim; or

2 (3) the department determines that continuation of the
3 policy would result in a violation of this code or any other law
4 governing the business of insurance in this state.

5 (c) An insurer may cancel a policy, other than a personal
6 automobile insurance policy, if there is an increase in the hazard
7 covered by the policy that is within the control of the insured and
8 that would produce an increase in the premium rate of the policy.

9 (d) An insurer may cancel a personal automobile insurance
10 policy if the driver's license or motor vehicle registration of the
11 named insured or any other motor vehicle operator who resides in the
12 same household as the named insured or who customarily operates an
13 automobile covered by the policy is suspended or revoked. An
14 insurer may not cancel a policy under this subsection if the named
15 insured consents to an endorsement terminating coverage under the
16 policy for the person whose license is suspended or revoked.

17 (e) Cancellation of a policy under Subsection (b), (c), or
18 (d) does not take effect until the 10th day after the date the
19 insurer mails notice of the cancellation to the insured.

20 (f) An insurer may cancel a personal automobile insurance
21 policy effective on any 12-month anniversary of the original
22 effective date of the policy if the insurer mails to the named
23 insured written notice of the cancellation not later than the 30th
24 day before the effective date of the cancellation.

25 (g) An insurer may cancel a personal automobile insurance
26 policy if the policy has been in effect less than 60 days. An
27 insurer may cancel any other insurance policy if the policy has been

1 in effect less than 90 days. (V.T.I.C. Art. 21.49-2B, Sec. 4.)

2 Sec. 551.105. NONRENEWAL OF POLICIES; NOTICE REQUIRED.
3 Unless the insurer has mailed written notice of nonrenewal to the
4 insured not later than the 30th day before the date on which the
5 insurance policy expires, an insurer must renew an insurance
6 policy, at the request of the insured, on the expiration of the
7 policy. (V.T.I.C. Art. 21.49-2B, Secs. 5, 11(b).)

8 Sec. 551.106. RENEWAL OF PERSONAL AUTOMOBILE INSURANCE
9 POLICIES. (a) An insurer may not refuse to renew a personal
10 automobile insurance policy solely because of the age of the person
11 covered by the policy.

12 (b) An insurer shall renew a personal automobile insurance
13 policy that was written for a term of less than one year, except
14 that the insurer may refuse to renew the policy on any 12-month
15 anniversary of the original effective date of the policy.
16 (V.T.I.C. Art. 21.49-2B, Sec. 6.)

17 Sec. 551.107. RENEWAL OF CERTAIN POLICIES; PREMIUM
18 SURCHARGE AUTHORIZED; NOTICE. (a) This section applies only to a
19 standard fire, homeowners, or farm or ranch owners insurance
20 policy.

21 (b) A claim under this section does not include a claim:
22 (1) resulting from a loss caused by natural causes; or
23 (2) that is filed but is not paid or payable under the
24 policy.

25 (c) An insurer may assess a premium surcharge at the time an
26 insurance policy is renewed if the insured has filed two or more
27 claims in the preceding policy year. The insurer may assess an

1 additional premium surcharge if an additional claim is made in the
2 following policy year. The department shall set the amount of any
3 surcharge that may be assessed under this subsection. The amount of
4 the surcharge may not exceed 10 percent of the total premium,
5 including any premium surcharge, actually paid by the insured in
6 the preceding policy year.

7 (d) Subject to Subsection (e), an insurer may refuse to
8 renew an insurance policy if the insured has filed three or more
9 claims under the policy in any three-year period.

10 (e) An insurer may notify an insured who has filed two
11 claims in a period of less than three years that the insurer may
12 refuse to renew the policy if the insured files a third claim during
13 the three-year period. If the insurer does not notify the insured
14 in accordance with this subsection, the insurer may not refuse to
15 renew the policy because of losses. The notice form must:

16 (1) list the policyholder's claims; and

17 (2) contain the sentence: "Another non-weather
18 related loss could cause us to refuse to renew your policy."

19 (f) An insurer that renews the insurance policy of an
20 insured who has filed three or more claims under the policy in a
21 three-year period may assess a premium surcharge in an amount set by
22 the department. (V.T.I.C. Art. 21.49-2B, Sec. 7.)

23 Sec. 551.108. INSURER RECORDS. (a) An insurer shall
24 maintain information regarding cancellation or nonrenewal of
25 insurance policies in accordance with the insurer's ordinary
26 practices for maintaining records of expired policies.

27 (b) The insurer shall make the information available to the

1 department on request. (V.T.I.C. Art. 21.49-2B, Sec. 8.)

2 Sec. 551.109. INSURER STATEMENT. An insurer shall, at the
3 request of an applicant for insurance or an insured, provide a
4 written statement of the reason for a declination, cancellation, or
5 nonrenewal of an insurance policy. The statement must comply with:

6 (1) Sections 551.002(b) and (c); and

7 (2) rules adopted under Section 551.002(d). (V.T.I.C.
8 Art. 21.49-2B, Sec. 9; Art. 21.49-2E, Sec. (a) (part).)

9 Sec. 551.110. LIABILITY FOR DISCLOSURE. An insurer or
10 agent or an employee of an insurer or agent is not liable for a
11 statement or disclosure made in good faith under this subchapter
12 unless the statement or disclosure was:

13 (1) known to be false; or

14 (2) made with malice or wilful intent to injure any
15 person. (V.T.I.C. Art. 21.49-2B, Sec. 10.)

16 Sec. 551.111. EFFECT OF NONCOMPLIANCE. A cancellation of
17 an insurance policy made in violation of this subchapter has no
18 effect. (V.T.I.C. Art. 21.49-2B, Sec. 11(a).)

19 Sec. 551.112. RULES. The commissioner may adopt rules
20 relating to the cancellation and nonrenewal of insurance policies.
21 (V.T.I.C. Art. 21.49-2B, Sec. 12.)

22 [Sections 551.113-551.150 reserved for expansion]

23 SUBCHAPTER D. CANCELLATION OR NONRENEWAL OF
24 CERTAIN POLICIES ISSUED TO ELECTED OFFICIALS

25 Sec. 551.151. DEFINITION. In this subchapter, "insurer"
26 has the meaning assigned by Section 551.101. (V.T.I.C. Art.
27 21.49-2D, Sec. (a).)

1 Sec. 551.152. ELECTED OFFICIALS. An insurer may not cancel
2 or refuse to renew an insurance policy based solely on the fact that
3 the policyholder is an elected official. (V.T.I.C. Art. 21.49-2D,
4 Sec. (b).)

5 CHAPTER 552. ILLEGAL PRICING PRACTICES

6 Sec. 552.001. APPLICABILITY OF CHAPTER

7 Sec. 552.002. FRAUDULENT INSURANCE ACT

8 Sec. 552.003. CHARGING DIFFERENT PRICES; OFFENSE

9 CHAPTER 552. ILLEGAL PRICING PRACTICES

10 Sec. 552.001. APPLICABILITY OF CHAPTER. This chapter does
11 not apply to the provision of a health care service to a:

12 (1) Medicaid or Medicare patient; or

13 (2) medically indigent person who qualifies for a
14 sliding fee scale. (V.T.I.C. Art. 21.79F, Sec. (d).)

15 Sec. 552.002. FRAUDULENT INSURANCE ACT. An offense under
16 Section 552.003 is a fraudulent insurance act under Chapter 701.
17 (V.T.I.C. Art. 21.79F, Sec. (c).)

18 Sec. 552.003. CHARGING DIFFERENT PRICES; OFFENSE. (a) A
19 person commits an offense if:

20 (1) the person knowingly or intentionally charges two
21 different prices for providing the same product or service; and

22 (2) the higher price charged is based on the fact that
23 an insurer will pay all or part of the price of the product or
24 service.

25 (b) An offense under this section is a Class B misdemeanor.
26 (V.T.I.C. Art. 21.79F, Secs. (a), (b).)

27 CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES

REGARDING HOLOCAUST VICTIMS

Sec. 553.001. DEFINITIONS

Sec. 553.002. SUSPENSION OF LIMITATIONS PERIOD

Sec. 553.003. VIOLATION BY INSURER

Sec. 553.004. EXAMINATION; ENFORCEMENT

CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES

REGARDING HOLOCAUST VICTIMS

Sec. 553.001. DEFINITIONS. In this chapter:

(1) "Holocaust victim" means a person who was killed or injured, or who lost financial assets or other property, as the result of discriminatory laws, policies, or actions directed against any discrete group of which the person was a member, during the period of 1920 to 1945, inclusive, in Germany, areas occupied by Germany, or countries allied with Germany.

(2) "Insurance policy" includes:

(A) a life insurance policy, an annuity, a property insurance policy, a casualty insurance policy, and a liability insurance policy; and

(B) reinsurance on a risk covered under a policy described by Paragraph (A).

(3) "Insurer" means an insurance company or other entity engaged in the business of insurance or reinsurance in this state. The term includes:

(A) a capital stock company, a mutual company, or a Lloyd's plan; and

(B) any parent, subsidiary, or affiliated company, at least 50 percent of the stock of which is in common

ownership with an insurer engaged in the business of insurance in this state. (V.T.I.C. Art. 21.74, Sec. 1.)

Sec. 553.002. SUSPENSION OF LIMITATIONS PERIOD. (a) Notwithstanding any other law, a Holocaust victim, or the heir, assignee, beneficiary, or successor of a Holocaust victim, who resides in this state and has a claim arising out of an insurance policy purchased or in effect in Europe before 1946 that was delivered, issued for delivery, or renewed by an insurer may bring an action in this state against an insurer to recover on that claim.

(b) An action brought under this section before December 31, 2012, may not be dismissed for failure to comply with any applicable limitations period. (V.T.I.C. Art. 21.74, Sec. 2.)

Sec. 553.003. VIOLATION BY INSURER. An insurer violates this chapter if the insurer fails to comply with a claim brought under this chapter by:

(1) denying the claim on the grounds that the claim is not timely; or

(2) asserting a statute of limitations defense in an action brought under Section 553.002. (V.T.I.C. Art. 21.74, Sec. 3(a).)

Sec. 553.004. EXAMINATION; ENFORCEMENT. (a) If the commissioner considers it necessary, the commissioner may initiate an examination of an insurer under Article 1.15.

(b) If the commissioner believes that an insurer is violating or has violated this chapter, the commissioner may:

(1) impose a sanction under Chapter 82;

(2) issue a cease and desist order under Chapter 83;

- 1 (3) assess an administrative penalty under Chapter 84;
2 or
3 (4) refer the matter to the attorney general for
4 appropriate enforcement. (V.T.I.C. Art. 21.74, Secs. 3(b), (c).)

5 CHAPTER 554. BURDEN OF PROOF AND PLEADING

6 Sec. 554.001. APPLICABILITY OF CHAPTER

7 Sec. 554.002. BURDEN OF PROOF AND PLEADING

8 CHAPTER 554. BURDEN OF PROOF AND PLEADING

9 Sec. 554.001. APPLICABILITY OF CHAPTER. This chapter
10 applies to each insurer or health maintenance organization engaged
11 in the business of insurance or the business of a health maintenance
12 organization in this state, regardless of form and however
13 organized, including:

- 14 (1) a stock life, health, or accident insurance
15 company;
16 (2) a mutual life, health, or accident insurance
17 company;
18 (3) a stock fire or casualty insurance company;
19 (4) a mutual fire or casualty insurance company;
20 (5) a Mexican casualty insurance company;
21 (6) a Lloyd's plan;
22 (7) a reciprocal or interinsurance exchange;
23 (8) a fraternal benefit society;
24 (9) a title insurance company;
25 (10) an attorney's title insurance company;
26 (11) a stipulated premium company;
27 (12) a nonprofit legal services corporation;

- 1 (13) a statewide mutual assessment company;
2 (14) a local mutual aid association;
3 (15) a local mutual burial association;
4 (16) an association exempt under Section 887.102;
5 (17) a nonprofit hospital, medical, or dental service
6 corporation, including a corporation subject to Chapter 842;
7 (18) a county mutual insurance company;
8 (19) a farm mutual insurance company; and
9 (20) an insurer or health maintenance organization
10 engaged in the business of insurance or the business of a health
11 maintenance organization in this state that does not hold a
12 certificate of authority issued by the department or is not
13 otherwise authorized to engage in business in this state.
14 (V.T.I.C. Art. 21.58, Subsec. (a).)

15 Sec. 554.002. BURDEN OF PROOF AND PLEADING. In a suit to
16 recover under an insurance or health maintenance organization
17 contract, the insurer or health maintenance organization has the
18 burden of proof as to any avoidance or affirmative defense that the
19 Texas Rules of Civil Procedure require to be affirmatively pleaded.
20 Language of exclusion in the contract or an exception to coverage
21 claimed by the insurer or health maintenance organization
22 constitutes an avoidance or an affirmative defense. (V.T.I.C. Art.
23 21.58, Subsec. (b).)

24 CHAPTER 555. FAILURE TO SATISFY JUDGMENT

25 Sec. 555.001. APPLICABILITY OF CHAPTER

26 Sec. 555.002. REVOCATION OF CERTIFICATE OF AUTHORITY

27 CHAPTER 555. FAILURE TO SATISFY JUDGMENT

1 Sec. 555.001. APPLICABILITY OF CHAPTER. This chapter does
2 not apply to an insurer subject to Chapter 841. (V.T.I.C. Art.
3 21.36 (part).)

4 Sec. 555.002. REVOCATION OF CERTIFICATE OF AUTHORITY. If
5 an execution issued on a final judgment rendered against an insurer
6 is not satisfied and discharged before the 31st day after the date
7 of notice of the execution's issuance, the insurer's certificate of
8 authority shall be revoked, and the insurer may not engage in the
9 business of insurance in this state until the execution is
10 satisfied. (V.T.I.C. Art. 21.36 (part).)

11 CHAPTER 556. UNFAIR METHODS OF COMPETITION AND UNFAIR

12 PRACTICES BY FINANCIAL INSTITUTIONS

13 SUBCHAPTER A. GENERAL PROVISIONS

14 Sec. 556.001. DEFINITIONS

15 Sec. 556.002. RULES

16 [Sections 556.003-556.050 reserved for expansion]

17 SUBCHAPTER B. UNFAIR METHODS OR PRACTICES

18 Sec. 556.051. UNFAIR METHOD OF COMPETITION OR UNFAIR

19 PRACTICE: TYING

20 Sec. 556.052. UNFAIR METHOD OF COMPETITION OR UNFAIR

21 PRACTICE: FAILURE TO DISCLOSE

22 [Sections 556.053-556.100 reserved for expansion]

23 SUBCHAPTER C. REGULATION OF PRACTICES

24 Sec. 556.101. PROHIBITION ON CERTAIN REFERRALS OR

25 SOLICITATIONS TO PURCHASE INSURANCE

26 Sec. 556.102. INSURANCE SALE WITH LOAN TRANSACTION

27 Sec. 556.103. DESIGNATION OF PLACE OF INSURANCE

ACTIVITIES

Sec. 556.104. USE OF CUSTOMER INFORMATION

[Sections 556.105-556.150 reserved for expansion]

SUBCHAPTER D. DISCLOSURES

Sec. 556.151. APPLICABILITY OF SUBCHAPTER

Sec. 556.152. PROMOTIONAL MATERIALS DISCLOSURE

Sec. 556.153. DISCLOSURE AT TIME OF LOAN APPLICATION

Sec. 556.154. FORM OF DISCLOSURE

CHAPTER 556. UNFAIR METHODS OF COMPETITION AND UNFAIR

PRACTICES BY FINANCIAL INSTITUTIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 556.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly or through one or more intermediaries, controls or is controlled by another person or is under common control with another person.

(2) "Depository institution" has the meaning assigned by Section 4001.003. (V.T.I.C. Art. 21.21-9, Sec. 1, as added Acts 75th Leg., R.S., Ch. 596.)

Sec. 556.002. RULES. The commissioner may adopt reasonable rules to comply with federal law applicable to the sale of insurance and for the implementation and administration of this chapter. (V.T.I.C. Art. 21.21-9, Sec. 7, as added Acts 75th Leg., R.S., Ch. 596.)

[Sections 556.003-556.050 reserved for expansion]

SUBCHAPTER B. UNFAIR METHODS OR PRACTICES

Sec. 556.051. UNFAIR METHOD OF COMPETITION OR UNFAIR

1 PRACTICE: TYING. (a) A depository institution engages in an
2 unfair method of competition or an unfair practice in the sale of
3 insurance by the depository institution if the depository
4 institution:

5 (1) is an agent and, as a condition of extending or
6 renewing credit, leasing or selling property, or furnishing
7 services, requires the purchase of insurance from the depository
8 institution or a subsidiary or affiliate of the depository
9 institution, or from or through a particular agent, insurer, or any
10 other person or entity;

11 (2) conditions the terms of credit or the sale or lease
12 of property on acquisition of insurance from or through the
13 depository institution, a subsidiary or affiliate of the depository
14 institution, or any other particular person or entity;

15 (3) rejects a required policy solely because the
16 policy has been issued or underwritten by a person or entity that is
17 not associated with the depository institution; or

18 (4) imposes a requirement on an agent or broker who is
19 not associated with the depository institution that is not imposed
20 on an agent or broker who is associated with the depository
21 institution or a subsidiary or affiliate of the depository
22 institution.

23 (b) This section does not prevent a person who lends money
24 or extends credit from placing insurance on property if the
25 mortgagor, borrower, or purchaser fails to provide required
26 insurance in accordance with the terms of the loan or credit
27 document. (V.T.I.C. Art. 21.21-9, Secs. 2(a) (part), (b), as added

1 Acts 75th Leg., R.S., Ch. 596.)

2 Sec. 556.052. UNFAIR METHOD OF COMPETITION OR UNFAIR
3 PRACTICE: FAILURE TO DISCLOSE. A depository institution engages
4 in an unfair method of competition or an unfair practice in the sale
5 of insurance by the depository institution if, on the premises of
6 the depository institution or in connection with a product offering
7 of the depository institution, the depository institution sells or
8 solicits the purchase of insurance or a person sells or solicits the
9 purchase of insurance recommended or sponsored by the depository
10 institution and the depository institution or person fails to
11 clearly disclose in all promotional materials relating to an
12 insurance product distributed to customers and potential customers
13 that:

14 (1) an insurance product sold through or in the
15 depository institution or a subsidiary or affiliate of the
16 depository institution is not insured by the Federal Deposit
17 Insurance Corporation;

18 (2) the insurance product is not issued, guaranteed,
19 or underwritten by the depository institution or the Federal
20 Deposit Insurance Corporation; and

21 (3) the insurance product involves investment risk, if
22 appropriate, including potential loss of principal. (V.T.I.C. Art.
23 21.21-9, Sec. 2(a) (part), as added Acts 75th Leg., R.S., Ch. 596.)

24 [Sections 556.053-556.100 reserved for expansion]

25 SUBCHAPTER C. REGULATION OF PRACTICES

26 Sec. 556.101. PROHIBITION ON CERTAIN REFERRALS OR
27 SOLICITATIONS TO PURCHASE INSURANCE. (a) An individual who is an

1 employee or agent of a depository institution or a subsidiary or
2 affiliate of a depository institution may not directly or
3 indirectly make a referral related to insurance to, or solicit the
4 purchase of any insurance by, a customer knowing that the customer
5 has applied for a loan or other extension of credit from a financial
6 institution, before:

7 (1) the customer receives a written commitment
8 relating to that loan or extension of credit; or

9 (2) if a written commitment has not been or will not be
10 issued in connection with the loan or extension of credit, the
11 customer receives notification of approval of that loan or
12 extension of credit by the financial institution and the financial
13 institution creates a written record of the approval.

14 (b) This section does not prohibit a depository institution
15 from:

16 (1) informing a customer that insurance is required in
17 connection with a loan;

18 (2) contacting a person in the course of a direct or
19 mass mailing to a group of persons in a manner that is not related to
20 the person's loan application or credit decision; or

21 (3) selling credit life, credit disability, credit
22 property, or involuntary unemployment insurance that is:

23 (A) specifically authorized by this code;

24 (B) approved for sale in this state; and

25 (C) sold in connection with a credit transaction.

26 (c) This section does not apply to an insurance policy
27 described by Section 556.151. (V.T.I.C. Art. 21.21-9, Secs. 3(c),

1 (e) (part), as added Acts 75th Leg., R.S., Ch. 596.)

2 Sec. 556.102. INSURANCE SALE WITH LOAN TRANSACTION. (a) If
3 insurance is offered or sold to a depository institution's customer
4 in connection with a loan transaction by the depository
5 institution, the insurance salesperson involved in that insurance
6 transaction may not be involved in that loan transaction and may not
7 be the person making that loan.

8 (b) This section does not apply to:

9 (1) a depository institution that has \$40 million or
10 less in total assets, as reported in the most recent Consolidated
11 Report of Condition and Income by the Federal Financial
12 Institutions Examination Council or any successor report required
13 by federal or state law; or

14 (2) a credit life, credit disability, credit property,
15 or involuntary unemployment insurance product that is:

16 (A) specifically authorized by this code;

17 (B) approved for sale in this state; and

18 (C) sold in connection with a credit transaction.

19 (V.T.I.C. Art. 21.21-9, Sec. 4, as added Acts 75th Leg., R.S., Ch.
20 596.)

21 Sec. 556.103. DESIGNATION OF PLACE OF INSURANCE ACTIVITIES.

22 (a) The place where a depository institution sells or solicits the
23 purchase of insurance or the place on the premises of a depository
24 institution where insurance is sold or solicited for purchase shall
25 be clearly and conspicuously indicated by signs so that the public
26 can readily distinguish the sale or solicitation as separate from
27 the lending and deposit-taking activities of the depository

1 institution.

2 (b) The commissioner may grant a waiver from the
3 requirements of this section to a person who files a written request
4 that:

5 (1) demonstrates that, due to the size of the physical
6 premises of the person, compliance with the requirements is not
7 possible; and

8 (2) identifies other steps that will be taken to
9 minimize customer confusion. (V.T.I.C. Art. 21.21-9, Sec. 6, as
10 added Acts 75th Leg., R.S., Ch. 596.)

11 Sec. 556.104. USE OF CUSTOMER INFORMATION. (a) In this
12 section:

13 (1) "Customer" means a person with an investment,
14 security, deposit, trust, or credit relationship with a financial
15 institution.

16 (2) "Nonpublic customer information" means
17 information relating to an individual that is derived from a bank
18 record, including information concerning insurance premiums, the
19 terms and conditions of insurance coverage, insurance expirations,
20 insurance claims, and insurance history of the individual. The
21 term does not include a customer's name, address, or telephone
22 number.

23 (b) A person may not use nonpublic customer information for
24 the purpose of selling or soliciting the purchase of insurance, or
25 provide nonpublic customer information to a third party for the
26 purpose of another's selling or soliciting the purchase of
27 insurance, unless:

1 (1) it is clearly and conspicuously disclosed that the
2 nonpublic customer information may be used for that purpose; and

3 (2) the customer has been provided an opportunity to
4 object before the time the information is used. (V.T.I.C. Art.
5 21.21-9, Sec. 5, as added Acts 75th Leg., R.S., Ch. 596.)

6 [Sections 556.105-556.150 reserved for expansion]

7 SUBCHAPTER D. DISCLOSURES

8 Sec. 556.151. APPLICABILITY OF SUBCHAPTER. This subchapter
9 does not apply to a credit life, credit accident and health, credit
10 property, or credit involuntary unemployment insurance policy that
11 is:

- 12 (1) specifically authorized by this code;
13 (2) approved for sale in this state; and
14 (3) sold in connection with a credit transaction.
15 (V.T.I.C. Art. 21.21-9, Sec. 3(e), as added Acts 75th Leg., R.S.,
16 Ch. 596.)

17 Sec. 556.152. PROMOTIONAL MATERIALS DISCLOSURE. (a) This
18 section applies to each agent that is a depository institution or
19 that, on the premises of a depository institution or in connection
20 with a product offering of a depository institution, sells or
21 solicits the purchase of insurance recommended or sponsored by the
22 depository institution.

23 (b) Promotional materials relating to an insurance product
24 distributed to a customer or potential customer must clearly
25 disclose that an insurance product sold through an agent affiliated
26 with a depository institution:

- 27 (1) is not insured by the Federal Deposit Insurance

1 Corporation;

2 (2) is not issued, guaranteed, or underwritten by the
3 depository institution or the Federal Deposit Insurance
4 Corporation; and

5 (3) involves investment risk, if appropriate,
6 including potential loss of principal. (V.T.I.C. Art. 21.21-9,
7 Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 596.)

8 Sec. 556.153. DISCLOSURE AT TIME OF LOAN APPLICATION. (a)
9 At the time a loan application is made, a depository institution
10 shall provide to the customer a written disclosure as required by
11 this section and Section 556.154.

12 (b) The disclosure must be separate from any loan
13 application or loan document.

14 (c) The depository institution employee who presents the
15 disclosure and the customer shall sign and date the disclosure.

16 (d) The depository institution shall maintain one copy of
17 the disclosure in the loan file and shall provide one copy to the
18 customer. (V.T.I.C. Art. 21.21-9, Sec. 3(b) (part), as added Acts
19 75th Leg., R.S., Ch. 596.)

20 Sec. 556.154. FORM OF DISCLOSURE. (a) The disclosure
21 required by Section 556.153 must be in substantially the following
22 form:

23 "CUSTOMER DISCLOSURE

24 "You have applied for a loan with the depository institution.
25 As permitted by Title 4, Finance Code, the depository institution
26 is requiring that collateral used to secure the loan be insured to
27 cover the amount of the loan to the extent insurance is available on

the property to be insured, against the usual and customary casualty losses.

"You have the right to provide this insurance either through existing policies already owned or controlled by you or by obtaining the insurance through any insurance agent or insurer authorized to engage in business in Texas.

"The depository institution, through its own insurance agency, can also make this insurance available to you. However, federal and state laws provide that the depository institution cannot require you to obtain insurance through the depository institution, its subsidiary, an affiliate, or any particular unaffiliated third party, either as a condition to obtaining this credit or to obtain special terms or consideration.

"Insurance products sold through or in the depository institution or its affiliate or subsidiary are not insured by the Federal Deposit Insurance Corporation and are not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation.

"You are not required or obligated to purchase insurance from the depository institution or any subsidiary, affiliate, or particular unaffiliated third party as a condition to obtaining your loan, and your decision as to insurance agents will not affect your credit terms in any way.

_____	_____
Customer	Date

Employee of Depository Institution"

(b) The commissioner may amend the disclosure form as necessary to comply with federal or state law. (V.T.I.C. Art. 21.21-9, Secs. 3(b) (part), (d), as added Acts 75th Leg., R.S., Ch. 596.)

CHAPTER 557. INSURED PROPERTY SUBJECT

TO SECURITY INTEREST

SUBCHAPTER A. INSURANCE PROCEEDS HELD BY LENDER

PENDING REPAIR OF RESIDENTIAL REAL PROPERTY

Sec. 557.001. DEFINITIONS

Sec. 557.002. NOTIFICATION BY LENDER TO INSURED

CONCERNING INSURANCE PROCEEDS

Sec. 557.003. LENDER'S RELEASE OR REFUSAL TO RELEASE

INSURANCE PROCEEDS

Sec. 557.004. PAYMENT OF INTEREST; RATE

Sec. 557.005. ACCRUAL OF INTEREST

Sec. 557.006. INTEREST NOT REQUIRED ON INSURANCE PROCEEDS

APPLIED TO REDUCE NOTE

[Sections 557.007-557.050 reserved for expansion]

SUBCHAPTER B. LIENHOLDER APPROVAL OF INSURANCE CLAIM

PAYMENT RELATING TO PERSONAL PROPERTY

Sec. 557.051. LIENHOLDER APPROVAL OF PAYMENT

Sec. 557.052. CIVIL PENALTY

CHAPTER 557. INSURED PROPERTY SUBJECT

TO SECURITY INTEREST

SUBCHAPTER A. INSURANCE PROCEEDS HELD BY LENDER

PENDING REPAIR OF RESIDENTIAL REAL PROPERTY

Sec. 557.001. DEFINITIONS. In this subchapter:

1 (1) "Lender" means a person holding a mortgage, lien,
2 deed of trust, or other security interest in property.

3 (2) "Residential real property" means:
4 (A) a single-family house;
5 (B) a duplex, triplex, or quadraplex; or
6 (C) a unit in a multi-unit residential structure
7 in which title to an individual unit is transferred to the owner of
8 the unit under a condominium or cooperative system. (V.T.I.C. Art.
9 21.48B, Sec. 1.)

10 Sec. 557.002. NOTIFICATION BY LENDER TO INSURED CONCERNING
11 INSURANCE PROCEEDS. (a) If a claim under an insurance policy for
12 damage to residential real property is paid to the insured and a
13 lender, and the lender holds all or part of the proceeds from the
14 insurance claim payment pending completion of all or part of the
15 repairs to the property, the lender shall notify the insured of each
16 requirement with which the insured must comply for the lender to
17 release the insurance proceeds.

18 (b) The notice required under this section must be provided
19 not later than the 10th day after the date the lender receives
20 payment of the insurance proceeds. (V.T.I.C. Art. 21.48B, Sec.
21 2(a).)

22 Sec. 557.003. LENDER'S RELEASE OR REFUSAL TO RELEASE
23 INSURANCE PROCEEDS. Not later than the 10th day after the date a
24 lender receives from the insured a request for release of all or
25 part of the insurance proceeds held by the lender, the lender shall:

26 (1) if the lender has received sufficient evidence of
27 the insured's compliance with the requirements specified by the

1 lender under Section 557.002 for release of the proceeds, release
2 to the insured, as requested, all or part of the proceeds; or

3 (2) provide notice to the insured that explains
4 specifically:

5 (A) the reason for the lender's refusal to
6 release the proceeds to the insured; and

7 (B) each requirement with which the insured must
8 comply for the lender to release the proceeds. (V.T.I.C. Art.
9 21.48B, Sec. 2(b).)

10 Sec. 557.004. PAYMENT OF INTEREST; RATE. A lender who fails
11 to provide notice as required by Section 557.002 or 557.003 or to
12 release insurance proceeds as required by Section 557.003 shall pay
13 to the insured interest at the rate of 10 percent a year on the
14 proceeds held by the lender. (V.T.I.C. Art. 21.48B, Sec. 3(a).)

15 Sec. 557.005. ACCRUAL OF INTEREST. (a) If a lender fails
16 to provide notice as required by Section 557.002 or 557.003,
17 interest begins to accrue on the date the lender received the
18 insurance proceeds.

19 (b) If a lender fails to release insurance proceeds as
20 required by Section 557.003, interest begins to accrue on the date
21 the lender receives sufficient evidence of the insured's compliance
22 with the requirements specified by the lender under Section 557.002
23 or 557.003 for release of the proceeds.

24 (c) Interest stops accruing on the date the lender complies
25 with Section 557.002 or 557.003, as applicable. (V.T.I.C. Art.
26 21.48B, Secs. 3(b), (c).)

27 Sec. 557.006. INTEREST NOT REQUIRED ON INSURANCE PROCEEDS

1 APPLIED TO REDUCE NOTE. A lender is not required to pay interest on
2 insurance proceeds applied, in accordance with the terms and
3 conditions of a deed of trust or other security agreement, to reduce
4 a note. (V.T.I.C. Art. 21.48B, Sec. 3(d).)

5 [Sections 557.007-557.050 reserved for expansion]

6 SUBCHAPTER B. LIENHOLDER APPROVAL OF INSURANCE CLAIM PAYMENT

7 RELATING TO PERSONAL PROPERTY

8 Sec. 557.051. LIENHOLDER APPROVAL OF PAYMENT. If payment
9 of an insurance claim relating to personal property requires the
10 endorsement of a check or draft by a holder of a lien on the property
11 or otherwise requires approval of the lienholder, not later than
12 the 14th business day after the date the lienholder receives a
13 request for the endorsement or other approval, the lienholder shall
14 provide:

15 (1) the endorsement or approval; or

16 (2) a written statement of the reason for denial of the
17 endorsement or approval to the person who requested the endorsement
18 or approval. (V.A.C.S. Art. 9031, Sec. 1.)

19 Sec. 557.052. CIVIL PENALTY. (a) A lienholder who violates
20 Section 557.051 is liable for a civil penalty not to exceed \$500 for
21 each violation.

22 (b) The attorney general may bring an action to collect a
23 civil penalty under this section. (V.A.C.S. Art. 9031, Sec. 2.)

24 CHAPTER 558. REFUND OF UNEARNED PREMIUM

25 Sec. 558.001. DEFINITION

26 Sec. 558.002. APPLICABILITY OF CHAPTER; REFUND OF

27 UNEARNED PREMIUM

1 Sec. 558.003. RULES AND GUIDELINES

2 Sec. 558.004. EFFECT ON INSURANCE PREMIUM FINANCE

3 COMPANY

4 CHAPTER 558. REFUND OF UNEARNED PREMIUM

5 Sec. 558.001. DEFINITION. In this chapter, "insurer" means
6 an insurance company or other entity authorized to engage in the
7 business of insurance in this state. The term includes:

8 (1) a stock life, health, or accident insurance
9 company;

10 (2) a mutual life, health, or accident insurance
11 company;

12 (3) a stock fire or casualty insurance company;

13 (4) a mutual fire or casualty insurance company;

14 (5) a Mexican casualty insurance company;

15 (6) a farm mutual insurance company;

16 (7) a county mutual insurance company;

17 (8) a Lloyd's plan;

18 (9) a reciprocal or insurance exchange;

19 (10) a fraternal benefit society;

20 (11) a stipulated premium company;

21 (12) a nonprofit legal services corporation;

22 (13) a statewide mutual assessment company;

23 (14) a local mutual aid association;

24 (15) a local mutual burial association;

25 (16) an association exempt under Section 887.102;

26 (17) a nonprofit hospital, medical, or dental service
27 corporation, including a corporation subject to Chapter 842;

- (18) a risk retention group;
- (19) a purchasing group;
- (20) an eligible surplus lines insurer; and
- (21) a guaranty association operating under Article 21.28-C or 21.28-D. (V.T.I.C. Art. 21.29, Sec. (a).)

Sec. 558.002. APPLICABILITY OF CHAPTER; REFUND OF UNEARNED PREMIUM. (a) This chapter applies to an insurer that issues an insurance policy that requires the insurer to maintain an unearned premium reserve for the portion of the written policy premium applicable to the unexpired or unused part of the policy period for which the premium has been paid.

(b) An insurer shall promptly refund the appropriate portion of any unearned premium to the policyholder if the policy:

- (1) has a remaining unearned premium reserve; and
- (2) is canceled or terminated by the insured or the insurer before the end of its term.

(c) A guaranty association shall promptly refund any unearned premium as described by Section 5(8), Article 21.28-C, or Sections 5(10) and 8(n), Article 21.28-D. (V.T.I.C. Art. 21.29, Secs. (b), (c).)

Sec. 558.003. RULES AND GUIDELINES. The commissioner shall:

- (1) adopt rules necessary to implement this chapter;
- and
- (2) establish appropriate guidelines to determine the portion of an unearned premium that must be refunded to a policyholder under this chapter. (V.T.I.C. Art. 21.29, Sec. (d).)

Sec. 558.004. EFFECT ON INSURANCE PREMIUM FINANCE COMPANY.
This chapter does not affect the obligation of an insurer to pay an
unearned premium to an insurance premium finance company in
accordance with Section 651.162. (V.T.I.C. Art. 21.29, Sec. (e).)

[Chapters 559-600 reserved for expansion]

SUBTITLE D. PRIVACY

CHAPTER 601. PRIVACY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 601.001. DEFINITIONS

Sec. 601.002. COMPLIANCE WITH FEDERAL LAW REQUIRED

Sec. 601.003. EXEMPTION

Sec. 601.004. TREATMENT OF CERTAIN HEALTH INFORMATION;

STRICTER RULES NOT PRECLUDED

[Sections 601.005-601.050 reserved for expansion]

SUBCHAPTER B. DEPARTMENT POWERS AND DUTIES

Sec. 601.051. RULES

Sec. 601.052. IMPLEMENTATION OF CERTAIN STANDARDS

[Sections 601.053-601.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Sec. 601.101. ENFORCEMENT BY DEPARTMENT

Sec. 601.102. INJUNCTIVE OR DECLARATORY RELIEF; CIVIL

PENALTY

CHAPTER 601. PRIVACY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 601.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a company that controls, is
controlled by, or is under common control with another company. For

1 the purposes of this subdivision, "control" has the meaning
2 described by Sections 823.005 and 823.151.

3 (2) "Authorization" has the meaning assigned by
4 Section 82.001.

5 (3) "Covered entity" means an individual or entity
6 that receives an authorization from the department. The term
7 includes an individual or entity described by Section 82.002.

8 (4) "Nonaffiliated third party" means an entity that
9 is not an affiliate of, or related to by common ownership or
10 affiliated by corporate control with, the covered entity. The term
11 does not include a joint employee of the entity. (V.T.I.C. Art.
12 28A.01.)

13 Sec. 601.002. COMPLIANCE WITH FEDERAL LAW REQUIRED. (a) A
14 covered entity shall comply with 15 U.S.C. Sections 6802 and 6803,
15 as amended, in the same manner as a financial institution is
16 required to comply under those sections.

17 (b) An entity that is a nonaffiliated third party in
18 relation to a covered entity shall comply with 15 U.S.C. Section
19 6802(c), as amended. (V.T.I.C. Art. 28A.02.)

20 Sec. 601.003. EXEMPTION. Section 601.002(a) does not apply
21 to a covered entity to the extent that the entity is acting solely
22 as an insurance agent, employee, or other authorized representative
23 for another covered entity. (V.T.I.C. Art. 28A.03.)

24 Sec. 601.004. TREATMENT OF CERTAIN HEALTH INFORMATION;
25 STRICTER RULES NOT PRECLUDED. This chapter does not affect the
26 authority of the department or another state agency to adopt
27 stricter rules governing the treatment of health information by a

1 covered entity if another law gives the department or agency that
2 authority, including a law or rule of this state related to the
3 privacy of individually identifiable health information under
4 Subtitle F, Title II, Health Insurance Portability and
5 Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as
6 amended. (V.T.I.C. Art. 28A.04.)

7 [Sections 601.005-601.050 reserved for expansion]

8 SUBCHAPTER B. DEPARTMENT POWERS AND DUTIES

9 Sec. 601.051. RULES. (a) The commissioner shall adopt:

10 (1) rules to implement this chapter; and

11 (2) any other rules necessary to carry out Subtitle A,
12 Title V, Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.),
13 as amended, to make this state eligible to override federal
14 regulations as described by 15 U.S.C. Section 6805(c), as amended.

15 (b) In adopting rules under this chapter, the commissioner
16 shall attempt to keep state privacy requirements consistent with
17 federal regulations adopted under Subtitle A, Title V,
18 Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.), as
19 amended. (V.T.I.C. Art. 28A.51.)

20 Sec. 601.052. IMPLEMENTATION OF CERTAIN STANDARDS. The
21 department shall implement standards as required by 15 U.S.C.
22 Section 6805(b), as amended. (V.T.I.C. Art. 28A.52.)

23 [Sections 601.053-601.100 reserved for expansion]

24 SUBCHAPTER C. ENFORCEMENT

25 Sec. 601.101. ENFORCEMENT BY DEPARTMENT. The department
26 shall enforce 15 U.S.C. Sections 6801-6805, as amended, to the
27 extent required by 15 U.S.C. Section 6805, as amended, and this

chapter. (V.T.I.C. Art. 28A.101.)

Sec. 601.102. INJUNCTIVE OR DECLARATORY RELIEF; CIVIL PENALTY. (a) The attorney general, after conferring with the commissioner, may institute an action for injunctive or declaratory relief to restrain a violation of this chapter.

(b) In addition to instituting an action for injunctive relief under Subsection (a), the attorney general, after conferring with the commissioner, may institute an action for civil penalties against a covered entity or nonaffiliated third party for a violation of this chapter. A civil penalty assessed under this section may not exceed \$3,000 for each violation.

(c) If the court in which an action under Subsection (b) is pending finds that violations of this chapter have occurred with a frequency that constitutes a pattern or practice, the court may assess a civil penalty not to exceed \$250,000.

(d) If the attorney general substantially prevails in an action for injunctive relief or a civil penalty under this section, the attorney general may recover reasonable attorney's fees, costs, and expenses incurred obtaining the relief or penalty, including court costs and witness fees. (V.T.I.C. Art. 28A.102.)

CHAPTER 602. PRIVACY OF HEALTH INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 602.001. DEFINITIONS

Sec. 602.002. APPLICABILITY OF CHAPTER TO COVERED

ENTITY REQUIRED TO COMPLY WITH CERTAIN

FEDERAL STANDARDS

Sec. 602.003. CONSTRUCTION OF CHAPTER

1 Sec. 602.004. RULES

2 [Sections 602.005-602.050 reserved for expansion]

3 SUBCHAPTER B. AUTHORIZED DISCLOSURE

4 OF CERTAIN HEALTH INFORMATION

5 Sec. 602.051. AUTHORIZATION FOR DISCLOSURE OF CERTAIN
6 HEALTH INFORMATION

7 Sec. 602.052. DELIVERY OF AUTHORIZATION FORM AND REQUEST FOR
8 AUTHORIZATION

9 Sec. 602.053. EXCEPTIONS

10 [Sections 602.054-602.100 reserved for expansion]

11 SUBCHAPTER C. PENALTIES AND ENFORCEMENT

12 Sec. 602.101. PROHIBITION

13 Sec. 602.102. INJUNCTION

14 Sec. 602.103. CIVIL PENALTY

15 Sec. 602.104. DISCIPLINARY ACTION

16 Sec. 602.105. EXCLUSION FROM STATE PROGRAMS

17 Sec. 602.106. REMEDIES AVAILABLE

18 CHAPTER 602. PRIVACY OF HEALTH INFORMATION

19 SUBCHAPTER A. GENERAL PROVISIONS

20 Sec. 602.001. DEFINITIONS. In this chapter:

21 (1) "Covered entity" means a person who holds or is
22 required to hold a license, registration, certificate of authority,
23 or other authorization under this code or another insurance law of
24 this state. The term includes:

25 (A) an insurance company, including:

26 (i) a county mutual insurance company;

27 (ii) a farm mutual insurance company;

- (iii) a fraternal benefit society;
- (iv) a group hospital service corporation;
- (v) a Lloyd's plan;
- (vi) a local mutual aid association;
- (vii) a mutual insurance company;
- (viii) a reciprocal or interinsurance exchange;
- (ix) a statewide mutual assessment company;
- and
- (x) a stipulated premium company;
- (B) a health maintenance organization; and
- (C) an insurance agent.

(2) "Health information" means information regarding an individual, other than the individual's age or gender, whether provided orally or recorded in any medium or form, that is created by or derived from the individual or a health care provider and that relates to:

- (A) the past, present, or future physical, mental, or behavioral health or condition of the individual;
- (B) the provision of health care to the individual; or
- (C) payment for the provision of health care to the individual.

(3) "Nonpublic personal health information" means health information:

- (A) that identifies an individual who is the subject of the information; or

1 (B) with respect to which there is a reasonable
2 basis to believe that the information could be used to identify an
3 individual. (V.T.I.C. Art. 28B.01.)

4 Sec. 602.002. APPLICABILITY OF CHAPTER TO COVERED ENTITY
5 REQUIRED TO COMPLY WITH CERTAIN FEDERAL STANDARDS. This chapter
6 does not apply to a covered entity that is required to comply with
7 the standards governing the privacy of individually identifiable
8 health information adopted by the United States secretary of health
9 and human services under Section 262(a), Health Insurance
10 Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d
11 et seq.). (V.T.I.C. Art. 28B.05.)

12 Sec. 602.003. CONSTRUCTION OF CHAPTER. (a) This chapter
13 does not preempt or supersede state law in effect on July 1, 2002,
14 that relates to the privacy of medical records, health information,
15 or insurance information.

16 (b) This chapter may not be construed to modify, limit, or
17 supersede the operation of the federal Fair Credit Reporting Act
18 (15 U.S.C. Section 1681 et seq.).

19 (c) This chapter may not be used as a basis for drawing an
20 inference that information is or is not transaction or experience
21 information under Section 603 of the federal Fair Credit Reporting
22 Act (15 U.S.C. Section 1681a). (V.T.I.C. Art. 28B.06.)

23 Sec. 602.004. RULES. The commissioner may adopt rules as
24 necessary to implement this chapter. (V.T.I.C. Art. 28B.08.)

25 [Sections 602.005-602.050 reserved for expansion]

26 SUBCHAPTER B. AUTHORIZED DISCLOSURE

27 OF CERTAIN HEALTH INFORMATION

1 Sec. 602.051. AUTHORIZATION FOR DISCLOSURE OF CERTAIN
2 HEALTH INFORMATION. (a) Except as provided by Section 602.053, a
3 covered entity must obtain authorization to disclose nonpublic
4 personal health information before disclosing the information.

5 (b) A request for authorization to disclose nonpublic
6 personal health information may be in written or electronic form
7 and must:

8 (1) state the identity of the consumer or customer who
9 is the subject of the information;

10 (2) describe:

11 (A) each type of information to be disclosed;

12 (B) each party to whom the covered entity intends
13 to disclose the information;

14 (C) the purpose of the disclosure;

15 (D) how the information will be used; and

16 (E) the procedure for revoking the
17 authorization;

18 (3) include the signature of:

19 (A) the consumer or customer who is the subject
20 of the information; or

21 (B) the individual who is legally empowered to
22 grant authorization;

23 (4) state the date the authorization is signed; and

24 (5) provide notice of:

25 (A) the period for which the authorization is
26 valid; and

27 (B) the consumer's or customer's right to revoke

1 the authorization at any time.

2 (c) The period for which the authorization is valid may not
3 exceed 24 months.

4 (d) The right of a consumer or customer to revoke an
5 authorization at any time is subject to the rights of an individual
6 who, before receiving notice of a revocation, acted in reliance on
7 the authorization.

8 (e) The covered entity shall retain the original or a copy
9 of the authorization in the records of the individual who is the
10 subject of the nonpublic personal health information. (V.T.I.C.
11 Art. 28B.02.)

12 Sec. 602.052. DELIVERY OF AUTHORIZATION FORM AND REQUEST
13 FOR AUTHORIZATION. (a) A covered entity may deliver to a consumer
14 or customer a request for authorization and an authorization form
15 only if the request and form are clear and conspicuous.

16 (b) A covered entity is required to include delivery of the
17 authorization form in a notice to a consumer or customer only if the
18 covered entity intends to disclose health information protected
19 under this chapter. (V.T.I.C. Art. 28B.03.)

20 Sec. 602.053. EXCEPTIONS. A covered entity may disclose
21 nonpublic personal health information to the extent that the
22 disclosure is necessary to perform the following insurance or
23 health maintenance organization functions on behalf of the covered
24 entity:

25 (1) the investigation or reporting of actual or
26 potential fraud, misrepresentation, or criminal activity;

27 (2) underwriting;

- 1 (3) the placement or issuance of an insurance policy
- 2 or evidence of coverage;
- 3 (4) loss control services;
- 4 (5) ratemaking or guaranty fund functions;
- 5 (6) reinsurance or excess loss insurance;
- 6 (7) risk management;
- 7 (8) case management;
- 8 (9) disease management;
- 9 (10) quality assurance;
- 10 (11) quality improvement;
- 11 (12) performance evaluation;
- 12 (13) health care provider credentialing verification;
- 13 (14) utilization review;
- 14 (15) peer review activities;
- 15 (16) actuarial, scientific, medical, or public policy
- 16 research;
- 17 (17) grievance procedures;
- 18 (18) the internal administration of compliance,
- 19 managerial, and information systems;
- 20 (19) policyholder or enrollee services;
- 21 (20) auditing;
- 22 (21) reporting;
- 23 (22) database security;
- 24 (23) the administration of consumer disputes and
- 25 inquiries;
- 26 (24) external accreditation standards;
- 27 (25) the replacement of a group benefit plan or

workers' compensation policy or program;

(26) activities in connection with a sale, merger, transfer, or exchange of all or part of a business or operating unit;

(27) any activity that permits disclosure without authorization under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as amended;

(28) disclosure that is required, or that is a lawful or appropriate method to enforce the covered entity's rights or the rights of other persons engaged, in carrying out a transaction or providing a product or service that the consumer requests or authorizes;

(29) claims administration, adjustment, and management;

(30) any activity that is:

(A) otherwise permitted by law;

(B) required by a governmental reporting authority; or

(C) required to comply with legal process; and

(31) any other insurance or health maintenance organization functions the commissioner approves that are:

(A) necessary for appropriate performance of insurance or health maintenance organization functions; and

(B) fair and reasonable to the interests of consumers. (V.T.I.C. Art. 28B.04.)

[Sections 602.054-602.100 reserved for expansion]

SUBCHAPTER C. PENALTIES AND ENFORCEMENT

Sec. 602.101. PROHIBITION. A covered entity may not knowingly or wilfully violate this chapter. (V.T.I.C. Art. 28B.07.)

Sec. 602.102. INJUNCTION. The attorney general may bring an action for injunctive relief to restrain a violation of this chapter. (V.T.I.C. Art. 28B.09, Sec. (a).)

Sec. 602.103. CIVIL PENALTY. (a) The attorney general may bring an action for a civil penalty against a covered entity or health care entity for a violation of this chapter.

(b) A civil penalty assessed under this section may not be less than \$3,000 for each violation.

(c) If the court in which an action under this section is pending finds that the violations have occurred with a frequency as to constitute a pattern or practice, the court may assess a civil penalty not to exceed \$250,000.

(d) A civil penalty authorized by this section is in addition to any other civil, administrative, or criminal action provided by law, including an action for injunctive relief provided by Section 602.102. (V.T.I.C. Art. 28B.09, Secs. (b), (c), (d).)

Sec. 602.104. DISCIPLINARY ACTION. (a) In addition to a penalty prescribed by this subchapter, a covered entity that violates this chapter is subject to investigation, disciplinary proceedings, and probation or suspension of the covered entity's license or other form of authorization to engage in business.

(b) If there is evidence that a covered entity has engaged in a pattern or practice of violating this chapter, the covered

entity's license or other form of authorization to engage in business may be revoked. (V.T.I.C. Art. 28B.10.)

Sec. 602.105. EXCLUSION FROM STATE PROGRAMS. If there is evidence that a covered entity has engaged in a pattern or practice of violating this chapter, in addition to the other penalties prescribed by this subchapter, the covered entity shall be excluded from participating in any state-funded health care program. (V.T.I.C. Art. 28B.11.)

Sec. 602.106. REMEDIES AVAILABLE. This subchapter does not affect any right of a person under other law to bring a cause of action or otherwise seek relief with respect to conduct that violates this chapter. (V.T.I.C. Art. 28B.12.)

[Chapters 603-650 reserved for expansion]

SUBTITLE E. PREMIUM FINANCING

CHAPTER 651. FINANCING OF INSURANCE PREMIUMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 651.001. DEFINITIONS

Sec. 651.002. CERTAIN CONDUCT NOT ENGAGING IN BUSINESS AS
INSURANCE PREMIUM FINANCE COMPANY

Sec. 651.003. RULES

Sec. 651.004. EMPLOYMENT OF EXAMINERS AND INVESTIGATORS;
PAYMENT OF EXPENSES

Sec. 651.005. DEPOSIT AND USE OF FEES

Sec. 651.006. ASSESSMENTS

Sec. 651.007. APPLICABILITY OF CONSUMER CREDIT PROTECTION
ACT AND REGULATION Z

Sec. 651.008. AUTHORITY OF GENERAL PROPERTY AND CASUALTY AGENTS

TO CHARGE INTEREST TO CERTAIN PERSONS

[Sections 651.009-651.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Sec. 651.051. LICENSE REQUIRED

Sec. 651.052. LICENSE FEE

Sec. 651.053. ENTITLEMENT OF BANKS AND SAVINGS AND LOAN

ASSOCIATIONS TO LICENSE

Sec. 651.054. APPLICATION FOR LICENSE; INVESTIGATION FEE;

EXEMPTION

Sec. 651.055. REFUSAL TO ISSUE LICENSE

Sec. 651.056. NOTICE OF ACTION ON APPLICATION

Sec. 651.057. ISSUANCE OF LICENSE

Sec. 651.058. RECIPROCAL LICENSE

Sec. 651.059. ISSUANCE OF MULTIPLE LICENSES

Sec. 651.060. SINGLE BUSINESS LOCATION AUTHORIZED

BY LICENSE

Sec. 651.061. APPEARANCE OF LICENSE; POSTING

Sec. 651.062. TRANSFER OR ASSIGNMENT OF LICENSE PROHIBITED

Sec. 651.063. TERM OF LICENSE

Sec. 651.064. PROCEDURE FOR LICENSE RENEWAL

Sec. 651.065. STAGGERED RENEWAL SYSTEM

[Sections 651.066-651.100 reserved for expansion]

SUBCHAPTER C. REGULATION OF INSURANCE

PREMIUM FINANCE COMPANIES

Sec. 651.101. BOOKS, ACCOUNTS, AND RECORDS

Sec. 651.102. ANNUAL REPORT

Sec. 651.103. BUSINESS NAME

- 1 Sec. 651.104. BUSINESS LOCATION
- 2 Sec. 651.105. RELOCATION OF PLACE OF BUSINESS
- 3 Sec. 651.106. BUSINESS PREMISES
- 4 Sec. 651.107. ENGAGING IN BUSINESS BY MAIL OR OUTSIDE
- 5 THE COMMUNITY
- 6 Sec. 651.108. CERTAIN CHARGES PROHIBITED
- 7 Sec. 651.109. LIMITATIONS ON RATES AND CHARGES
- 8 Sec. 651.110. REBATE OF FINANCE CHARGE
- 9 Sec. 651.111. DECEPTIVE ADVERTISING PROHIBITED
- 10 [Sections 651.112-651.150 reserved for expansion]
- 11 SUBCHAPTER D. PREMIUM FINANCE AGREEMENTS
- 12 Sec. 651.151. REQUIRED FORM AND CONTENTS OF PREMIUM
- 13 FINANCE AGREEMENT
- 14 Sec. 651.152. OTHER REQUIRED CONTENTS
- 15 Sec. 651.153. FORM OF DISCLOSURES
- 16 Sec. 651.154. CONSOLIDATION OF INCREASE ATTRIBUTABLE
- 17 TO AMENDMENT OF RATE CLASSIFICATION
- 18 Sec. 651.155. RESPONSIBILITIES OF INSURANCE AGENT
- 19 Sec. 651.156. TAKING OF INCOMPLETE PREMIUM FINANCE
- 20 AGREEMENT PROHIBITED
- 21 Sec. 651.157. PERFECTION OF PREMIUM FINANCE AGREEMENT AS
- 22 SECURED TRANSACTION: FILING NOT REQUIRED
- 23 Sec. 651.158. PREPAYMENT AND REFUND
- 24 Sec. 651.159. DEFAULT CHARGE
- 25 Sec. 651.160. POWER OF ATTORNEY
- 26 Sec. 651.161. CANCELLATION OF INSURANCE CONTRACT
- 27 Sec. 651.162. RETURN OF UNEARNED PREMIUMS AND COMMISSIONS

1 Sec. 651.163. ASSIGNMENT OF PREMIUM FINANCE AGREEMENT

2 Sec. 651.164. RESTRICTIONS ON PREMIUM FINANCE AGREEMENTS

3 Sec. 651.165. REQUIRED NOTICE OF CERTAIN PREMIUM FINANCE
4 AGREEMENTS

5 Sec. 651.166. TAKING, RECEIVING, OR CHARGING
6 UNAUTHORIZED AMOUNT

7 Sec. 651.167. EFFECT OF LICENSE REVOCATION, SUSPENSION,
8 OR SURRENDER ON PREMIUM FINANCE AGREEMENT

9 [Sections 651.168-651.200 reserved for expansion]

10 SUBCHAPTER E. DISCIPLINARY PROCEDURES AND
11 PENALTIES; OFFENSES

12 Sec. 651.201. EXAMINATIONS AND INVESTIGATIONS OF LICENSE
13 HOLDERS

14 Sec. 651.202. CONFIDENTIALITY OF REPORTS AND RELATED
15 MATERIAL

16 Sec. 651.203. HEARINGS AND INVESTIGATIONS; SUBPOENA POWER

17 Sec. 651.204. REVOCATION OR SUSPENSION OF LICENSE

18 Sec. 651.205. ISSUANCE OF REVOCATION OR SUSPENSION ORDER

19 Sec. 651.206. SURRENDER OF LICENSE; EFFECT

20 Sec. 651.207. LICENSE REINSTATEMENT

21 Sec. 651.208. OFFENSE

22 Sec. 651.209. SANCTIONS; CEASE AND DESIST ORDERS

23 CHAPTER 651. FINANCING OF INSURANCE PREMIUMS

24 SUBCHAPTER A. GENERAL PROVISIONS

25 Sec. 651.001. DEFINITIONS. In this chapter:

26 (1) "Annual percentage rate" means the annual
27 percentage rate of finance charge determined under the Consumer

1 Credit Protection Act and Regulation Z.

2 (2) "Consumer Credit Protection Act" means the
3 Consumer Credit Protection Act of 1970 (15 U.S.C. Section 1601 et
4 seq.; 18 U.S.C. Section 891 et seq.).

5 (3) "Insurance premium finance company" means:

6 (A) a person engaged in the business of making
7 loans under this chapter by entering into premium finance
8 agreements with insureds or prospective insureds;

9 (B) a person engaged in the business of acquiring
10 premium finance agreements from insurance agents or brokers or from
11 other insurance premium finance companies; or

12 (C) an insurance agent or broker making loans
13 under this chapter who holds premium finance agreements made and
14 delivered by insureds that are payable to the agent or broker or to
15 the agent's or broker's order.

16 (4) "Insured" means a person who enters into a premium
17 finance agreement with an insurance premium finance company.

18 (5) "Insurer" means an entity organized or authorized
19 to engage in the business of insurance under this code as a capital
20 stock insurance company, title insurance company, reciprocal or
21 interinsurance exchange, Lloyd's plan, fraternal benefit society,
22 mutual or mutual assessment company of any kind, statewide mutual
23 assessment company, local mutual aid association, burial
24 association, county or farm mutual insurance company, fidelity,
25 guaranty, or surety company, or trust company.

26 (6) "License holder" means an insurance premium
27 finance company that holds a license issued under Subchapter B.

1 (7) "Person" means an individual, partnership,
2 corporation, joint venture, trust, association, or other legal
3 entity, regardless of organization.

4 (8) "Premium finance agreement" means an agreement by
5 which an insured or prospective insured promises to pay to an
6 insurance premium finance company the amount advanced or to be
7 advanced under the agreement to an insurer or to an insurance agent
8 in payment of the premiums on an insurance contract.

9 (9) "Regulation Z" means the federal regulations
10 adopted under the Consumer Credit Protection Act as 12 C.F.R.
11 Section 226.1 et seq. (V.T.I.C. Art. 24.01, Subdivs. (1) (part),
12 (2), (4), (5), (6), (7), (8); New.)

13 Sec. 651.002. CERTAIN CONDUCT NOT ENGAGING IN BUSINESS AS
14 INSURANCE PREMIUM FINANCE COMPANY. (a) The preparation or
15 delivery by an insurance agent of a premium finance agreement or
16 disclosure statement required by Section 651.155 on behalf of the
17 insured does not constitute engaging in business as an insurance
18 premium finance company.

19 (b) Subsection (a) does not apply to a premium finance
20 agreement held for the benefit of the insurance agent as provided by
21 Section 651.001(3)(C). (V.T.I.C. Art. 24.01, Subdiv. (1)(A)
22 (part); Art. 24.04, Sec. (c) (part).)

23 Sec. 651.003. RULES. (a) The commissioner may adopt and
24 enforce rules necessary to administer this chapter.

25 (b) The rules may contain classifications,
26 differentiations, or other provisions and provide for adjustments
27 or exceptions for any class of transactions necessary to:

- 1 (1) accomplish the purposes of this chapter;
- 2 (2) prevent circumvention or evasion of this chapter;
- 3 or
- 4 (3) facilitate compliance with this chapter.

5 (c) A rule adopted by the commissioner may not contain any
6 classification, differentiation, or other provision with respect
7 to any class of transactions or provide for any adjustment or
8 exception for any class of transactions that would result in a less
9 stringent disclosure requirement than required for that class of
10 transactions by the Consumer Credit Protection Act or Regulation Z.
11 (V.T.I.C. Art. 24.09.)

12 Sec. 651.004. EMPLOYMENT OF EXAMINERS AND INVESTIGATORS;
13 PAYMENT OF EXPENSES. The department may:

14 (1) employ persons as necessary to examine or
15 investigate and make reports on alleged violations of this chapter
16 and compliance with any other provision of this code by a license
17 holder;

18 (2) pay the salaries and expenses of persons described
19 by Subdivision (1) and of all office employees; and

20 (3) pay an expense necessary to enforce this chapter.
21 (V.T.I.C. Art. 24.06, Sec. (d) (part).)

22 Sec. 651.005. DEPOSIT AND USE OF FEES. Each fee collected
23 under this chapter:

24 (1) shall be deposited to the credit of the Texas
25 Department of Insurance operating account; and

26 (2) may be used by the department to enforce this
27 chapter. (V.T.I.C. Art. 24.03, Sec. (h) (part); Art. 24.06, Sec.

1 (d) (part).)

2 Sec. 651.006. ASSESSMENTS. (a) A license holder shall pay
3 to the department:

4 (1) an amount imposed by the department to cover the
5 direct and indirect cost of examinations and investigations made
6 under this chapter; and

7 (2) a proportionate share of the general
8 administrative expense attributable to the regulation of license
9 holders.

10 (b) Each amount required by this section is in addition to
11 any investigation or license fee imposed under Subchapter B.
12 (V.T.I.C. Art. 24.06, Sec. (c).)

13 Sec. 651.007. APPLICABILITY OF CONSUMER CREDIT PROTECTION
14 ACT AND REGULATION Z. A transaction that is subject to this chapter
15 is also subject to:

16 (1) the Consumer Credit Protection Act; and

17 (2) the applicable provisions of Regulation Z.
18 (V.T.I.C. Art. 24.12.)

19 Sec. 651.008. AUTHORITY OF GENERAL PROPERTY AND CASUALTY
20 AGENTS TO CHARGE INTEREST TO CERTAIN PERSONS. (a) Notwithstanding
21 any other law, a general property and casualty agent who holds a
22 license under Chapter 4051 may enter into a written agreement with a
23 purchaser of insurance from the agent that provides for the payment
24 of interest to the agent on any amount due to the agent for the
25 insurance purchased. The interest is computed at a rate not to
26 exceed the greater of:

27 (1) a rate allowed by Chapter 303, Finance Code; or

1 (2) the rate of one percent a month.

2 (b) A claim or defense of usury may not be raised in
3 connection with a written agreement under this section. (V.T.I.C.
4 Art. 24.20.)

5 [Sections 651.009-651.050 reserved for expansion]

6 SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

7 Sec. 651.051. LICENSE REQUIRED. Unless the person is a
8 license holder, a person may not:

9 (1) negotiate, transact, or engage in the business of
10 insurance premium financing in this state; or

11 (2) contract for, charge, or receive directly or
12 indirectly on or in connection with an insurance premium financing
13 any charge, regardless of whether the charge is for interest,
14 compensation, consideration, expense, or otherwise, if in the
15 aggregate the amount of the charge exceeds the amount the person
16 would be permitted by law to charge if the person were not a license
17 holder. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

18 Sec. 651.052. LICENSE FEE. (a) The department shall
19 establish the fee for a license under this subchapter in an amount
20 not to exceed \$200.

21 (b) The fee for a license issued after June 30 may not exceed
22 \$100.

23 (c) Section 201.001 applies to fees collected under this
24 section. (V.T.I.C. Art. 24.03, Secs. (f) (part), (h) (part).)

25 Sec. 651.053. ENTITLEMENT OF BANKS AND SAVINGS AND LOAN
26 ASSOCIATIONS TO LICENSE. (a) A bank or a savings and loan
27 association is entitled to receive a license under this subchapter

1 if the bank or savings and loan association:

2 (1) is engaging in business under the laws of this
3 state or the United States; and

4 (2) notifies the department of its intention to
5 operate under this chapter.

6 (b) On receipt of notice under Subsection (a)(2), the
7 department shall immediately issue a license to the bank or savings
8 and loan association. (V.T.I.C. Art. 24.02, Sec. (b).)

9 Sec. 651.054. APPLICATION FOR LICENSE; INVESTIGATION FEE;
10 EXEMPTION. (a) An application for a license to engage in the
11 business of insurance premium financing must:

12 (1) be in writing on a form prescribed by the
13 commissioner; and

14 (2) be accompanied by a nonrefundable investigation
15 fee in an amount not to exceed \$400 as established by the
16 department.

17 (b) A person who on January 1, 1980, held a license under
18 Chapter 3, Title 79, Revised Statutes (Article 5069-3.01 et seq.,
19 Vernon's Texas Civil Statutes), is not required to pay an
20 investigation fee.

21 (c) Section 201.001 applies to fees collected under this
22 section. (V.T.I.C. Art. 24.03, Secs. (a), (e), (g), (h) (part).)

23 Sec. 651.055. REFUSAL TO ISSUE LICENSE. The department may
24 refuse to issue a license to an applicant if the department
25 determines that:

26 (1) the financial responsibility, experience,
27 character, or general fitness of the applicant or any person

1 associated with the applicant does not command the confidence of
2 the community and does not warrant the belief that the applicant
3 will engage in the business of insurance premium financing
4 honestly, fairly, and efficiently; or

5 (2) the applicant does not have available for the
6 operation of the business net assets of at least \$25,000. (V.T.I.C.
7 Art. 24.03, Sec. (c).)

8 Sec. 651.056. NOTICE OF ACTION ON APPLICATION. Not later
9 than the 90th day after the date the department receives an
10 application under Section 651.054, the department shall notify the
11 applicant that:

12 (1) the application has been approved and the
13 department will issue a license to the applicant on payment of the
14 required license fee; or

15 (2) the application has been denied. (V.T.I.C. Art.
16 24.03, Sec. (b).)

17 Sec. 651.057. ISSUANCE OF LICENSE. After approval of an
18 application and on receipt of the required license fee, the
19 department shall:

20 (1) issue a license authorizing the license holder to
21 engage in business as an insurance premium finance company at the
22 location specified in the license holder's application; and

23 (2) send the license to the applicant. (V.T.I.C. Art.
24 24.03, Secs. (d), (f) (part).)

25 Sec. 651.058. RECIPROCAL LICENSE. The department may waive
26 any license requirement for an applicant who holds a valid license
27 from another state that has license requirements substantially

1 equivalent to the requirements prescribed by this state. (V.T.I.C.
2 Art. 24.03, Sec. (k).)

3 Sec. 651.059. ISSUANCE OF MULTIPLE LICENSES. The
4 department may issue a person more than one license under this
5 subchapter but may not issue one person more than 60 of those
6 licenses. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

7 Sec. 651.060. SINGLE BUSINESS LOCATION AUTHORIZED BY
8 LICENSE. A license authorizes the license holder to maintain only
9 one location where the business of insurance premium financing may
10 be conducted. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

11 Sec. 651.061. APPEARANCE OF LICENSE; POSTING. (a) A
12 license must state the name and address of the license holder.

13 (b) The license must be conspicuously posted at the location
14 where the license holder engages in the business of insurance
15 premium financing. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

16 Sec. 651.062. TRANSFER OR ASSIGNMENT OF LICENSE PROHIBITED.
17 A license may not be transferred or assigned. (V.T.I.C. Art. 24.04,
18 Sec. (a) (part).)

19 Sec. 651.063. TERM OF LICENSE. Unless a staggered renewal
20 system is adopted under Section 651.065, a license is issued for the
21 calendar year and remains valid until December 31 of that year,
22 unless suspended, revoked, or surrendered in accordance with
23 Section 651.204 or 651.206. (V.T.I.C. Art. 24.03, Sec. (f)
24 (part).)

25 Sec. 651.064. PROCEDURE FOR LICENSE RENEWAL. (a) A license
26 holder may renew an unexpired license by paying the required
27 renewal fee to the department.

1 (b) A person whose license has been expired for 90 days or
2 less may renew the license by paying to the department:

3 (1) the required renewal fee; and

4 (2) an additional fee equal to one-half of the
5 original license fee.

6 (c) A person whose license has been expired for more than 90
7 days but less than two years may renew the license by paying to the
8 department:

9 (1) all unpaid renewal fees; and

10 (2) an additional fee equal to the original license
11 fee.

12 (d) A person whose license has been expired for two years or
13 more may not renew the license. The person may obtain a new license
14 by complying with the requirements and procedures for obtaining an
15 original license.

16 (e) Not later than the 30th day before the date a person's
17 license expires, the department shall send written notice of the
18 impending license expiration to the person at the person's last
19 known address.

20 (f) This section may not be construed to prevent the
21 department from denying or refusing to renew a license under an
22 applicable law or a rule adopted by the commissioner. (V.T.I.C.
23 Art. 24.03, Sec. (i).)

24 Sec. 651.065. STAGGERED RENEWAL SYSTEM. (a) The
25 commissioner by rule may adopt a system under which licenses expire
26 on various dates during the year.

27 (b) For a year in which the license expiration date is less

1 than one year from the date of license issuance or the anniversary
2 of that date, the license fee shall be prorated so that each license
3 holder pays only that portion of the license fee allocable to the
4 number of months during which the license is valid. On each
5 subsequent renewal of the license, a license holder must pay the
6 total renewal fee. (V.T.I.C. Art. 24.03, Sec. (j).)

7 [Sections 651.066-651.100 reserved for expansion]

8 SUBCHAPTER C. REGULATION OF INSURANCE PREMIUM

9 FINANCE COMPANIES

10 Sec. 651.101. BOOKS, ACCOUNTS, AND RECORDS. (a) A license
11 holder shall maintain books, accounts, and records in sufficient
12 detail to enable a representative of the department to determine
13 whether the license holder is in compliance with this chapter and
14 rules adopted by the commissioner.

15 (b) A license holder shall maintain for inspection the
16 license holder's books, accounts, and records, including any cards
17 used in a card system, for at least four years after the date the
18 final entry of any premium finance agreement is recorded in those
19 books, accounts, and records. (V.T.I.C. Art. 24.10, Sec. (a).)

20 Sec. 651.102. ANNUAL REPORT. On or before April 1 of each
21 year, a license holder shall file with the department a report
22 containing information required by the department concerning the
23 business and operations of the license holder during the preceding
24 calendar year at each licensed location where the license holder
25 engages in the business of insurance premium financing in this
26 state. (V.T.I.C. Art. 24.10, Sec. (b).)

27 Sec. 651.103. BUSINESS NAME. A license holder may not

1 engage in the business of insurance premium financing under any
2 name other than the name stated on the license. (V.T.I.C. Art.
3 24.04, Sec. (c) (part).)

4 Sec. 651.104. BUSINESS LOCATION. A license holder may not
5 engage in the business of insurance premium financing at any
6 location other than the address stated on the license. (V.T.I.C.
7 Art. 24.04, Sec. (c) (part).)

8 Sec. 651.105. RELOCATION OF PLACE OF BUSINESS. (a) A
9 license holder who proposes to relocate the place where the holder
10 engages in the business of insurance premium financing shall give
11 written notice of the proposed change to the department.

12 (b) If the department approves the proposed relocation, the
13 department shall issue an endorsement to the license holder
14 indicating the change and the date of the change.

15 (c) The endorsement authorizes the license holder to engage
16 in the business of insurance premium financing at the new location.
17 The license holder shall attach the endorsement to the license for
18 that location. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

19 Sec. 651.106. BUSINESS PREMISES. (a) Except as provided by
20 Subsection (b), a license holder may engage in the business of
21 insurance premium financing:

22 (1) in any office, suite, room, or place of business in
23 which any other business is solicited or engaged in; or

24 (2) in association or in conjunction with any other
25 business.

26 (b) Subsection (a) does not apply if the department:

27 (1) determines, after a hearing, that the conduct by

1 the license holder of the other business at the location for which
2 the license was issued has concealed evasions of this chapter; and

3 (2) orders the license holder in writing to stop
4 engaging in the business of insurance premium financing at that
5 location. (V.T.I.C. Art. 24.04, Sec. (b).)

6 Sec. 651.107. ENGAGING IN BUSINESS BY MAIL OR OUTSIDE THE
7 COMMUNITY. This chapter does not prohibit a license holder from
8 engaging in the business of insurance premium financing:

9 (1) by mail; or

10 (2) with persons who do not reside in the same
11 community as the licensed location. (V.T.I.C. Art. 24.04, Sec.
12 (d).)

13 Sec. 651.108. CERTAIN CHARGES PROHIBITED. In connection
14 with a premium finance agreement entered into under this chapter,
15 an insurance charge or any other charge or fee may not be imposed
16 unless the charge or fee is authorized by this chapter. (V.T.I.C.
17 Art. 24.15 (part).)

18 Sec. 651.109. LIMITATIONS ON RATES AND CHARGES. (a) An
19 insurance premium finance company may not take or receive from an
20 insured a greater rate or charge than is authorized by Chapter 342,
21 Finance Code.

22 (b) For purposes of this section, a charge begins on the
23 earlier of:

24 (1) the date from which the insurer requires payment
25 of the premium and payment was made to the insurer for the financed
26 policy; or

27 (2) the effective date of the policy.

1 (c) The finance charge is computed on the balance of the
2 premiums due after subtracting any down payment made by the insured
3 in accordance with the premium finance agreement. (V.T.I.C. Art.
4 24.15 (part).)

5 Sec. 651.110. REBATE OF FINANCE CHARGE. (a) An insurance
6 premium finance company or an employee of an insurance premium
7 finance company may not:

8 (1) pay, allow, or offer to pay or allow in any manner
9 to an insurance agent or broker or an employee of an insurance agent
10 or broker or to any other person any consideration or compensation,
11 from the charge for financing specified in the premium finance
12 agreement or from another source; or

13 (2) give or offer to give any valuable consideration
14 or inducement of any kind directly or indirectly to an insurance
15 agent or broker or an employee of an insurance agent or broker.

16 (b) Subsection (a)(2) does not prohibit the giving or
17 offering of an article of merchandise that has a value of \$1 or less
18 on which there is an advertisement of the insurance premium finance
19 company.

20 (c) Subsection (a) does not prohibit an insurance premium
21 finance company from making a payment under a contractual agreement
22 with a validly organized and operating association of insurance
23 agents or a subsidiary of the association if no part of a payment
24 received under the agreement:

25 (1) is distributed to an insurance agent or broker or
26 an employee of an insurance agent or broker; or

27 (2) inures directly to the benefit of a member of the

1 association or an employee of the member.

2 (d) A contractual agreement under Subsection (c):

3 (1) must be in writing; and

4 (2) is not valid until department approval is
5 received. (V.T.I.C. Art. 24.14, Sec. (a).)

6 Sec. 651.111. DECEPTIVE ADVERTISING PROHIBITED. (a) A
7 license holder may not advertise or cause to be advertised in any
8 manner any false, misleading, or deceptive statement or
9 representation with regard to the rates, terms, or conditions of a
10 premium finance agreement.

11 (b) If rates or charges are stated in advertising, the
12 license holder must express the rates or charges in terms of a
13 simple annual percentage rate as defined by federal law. (V.T.I.C.
14 Art. 24.13.)

15 [Sections 651.112-651.150 reserved for expansion]

16 SUBCHAPTER D. PREMIUM FINANCE AGREEMENTS

17 Sec. 651.151. REQUIRED FORM AND CONTENTS OF PREMIUM FINANCE
18 AGREEMENT. (a) A premium finance agreement must be in writing on a
19 form approved by the commissioner.

20 (b) A premium finance agreement must be dated and signed by
21 the insured. An agreement may be signed on behalf of the insured by
22 the insured's agent if:

23 (1) the agreement contains policies for other than
24 personal, family, or household purposes; and

25 (2) the premiums for the policies exceed \$1,000.

26 (c) A premium finance agreement must contain:

27 (1) the name and business address of the insurance

1 agent or broker negotiating the related insurance contract;

2 (2) the name and residence or business address of the
3 insured as specified by the insured;

4 (3) the name and business location of the insurance
5 premium finance company to which payments are to be made;

6 (4) a description of each insurance contract involved;

7 (5) the amount of the premium for each insurance
8 contract;

9 (6) the total amount of the premiums for all insurance
10 contracts;

11 (7) the amount of any down payment;

12 (8) the principal balance, which is the difference
13 between the amounts under Subdivisions (6) and (7);

14 (9) the total amount of the finance charge, which must
15 describe each amount included and use the term "finance charge";
16 and

17 (10) the balance payable by the insured, which is the
18 sum of the amounts under Subdivisions (8) and (9). (V.T.I.C. Art.
19 24.11, Secs. (a), (b), (c).)

20 Sec. 651.152. OTHER REQUIRED CONTENTS. In addition to the
21 items required by Section 651.151, a premium finance agreement must
22 contain the following, as applicable:

23 (1) the finance charge expressed as an annual
24 percentage rate, using the term "annual percentage rate";

25 (2) the number of installments required under the
26 agreement;

27 (3) the amount of each installment expressed in

dollars;

(4) the due date or period of each installment;

(5) the amount or method of computing the amount of any default or delinquency charge that is payable in the event of late payment; and

(6) the method of computing any unearned portion of the finance charge in the event of prepayment of the obligation. (V.T.I.C. Art. 24.11, Sec. (d).)

Sec. 651.153. FORM OF DISCLOSURES. (a) The disclosures required by Sections 651.151 and 651.152 must be made clearly, conspicuously, and in meaningful sequence.

(b) If the term "finance charge" or "annual percentage rate" is required to be used, the term must be printed more conspicuously than other required terminology.

(c) Each numerical amount or percentage must be expressed as a figure and:

(1) legibly handwritten; or

(2) printed in not less than the equivalent of 10-point type, 75/1,000-inch computer type, or elite-size typewritten numerals. (V.T.I.C. Art. 24.11, Sec. (e).)

Sec. 651.154. CONSOLIDATION OF INCREASE ATTRIBUTABLE TO AMENDMENT OF RATE CLASSIFICATION. (a) If, in a premium finance agreement, a change in an insured's policy that is caused by an amendment of the rate classification by endorsement or otherwise results in an increased principal balance and the amount under the previous contract has not been fully paid, the subsequent increase, at the insured's option, may be consolidated with the previous

1 contract if the agreement provides for consolidation.

2 (b) A consolidation under this section may be accomplished
3 by a memorandum of agreement between the agent and the insured if,
4 before the first scheduled payment date of the amended transaction,
5 the insurance premium finance company provides to the insured the
6 following information in writing:

- 7 (1) the amount of the premium increase;
- 8 (2) the down payment on the increase;
- 9 (3) the principal amount of the increase;
- 10 (4) the total amount of any finance charge on the
11 increase;
- 12 (5) the total of the additional balance due;
- 13 (6) the outstanding balance due under the original
14 agreement;
- 15 (7) the balance due under the consolidated agreement;
- 16 (8) the annual percentage rate of any finance charge
17 on the additional balance due;
- 18 (9) the revised schedule of payments;
- 19 (10) the amount or method of computing the amount of
20 any default, deferment, or similar charge authorized by Chapter
21 342, Finance Code, that is payable in the event of late payment; and
22 (11) the method of computing any unearned portion of
23 the finance charge in the event of prepayment of the obligation.
24 (V.T.I.C. Art. 24.11, Secs. (g), (h).)

25 Sec. 651.155. RESPONSIBILITIES OF INSURANCE AGENT. An
26 insurance agent shall:

- 27 (1) prepare a premium finance agreement; and

1 (2) deliver to the insured each disclosure statement
2 required by law. (V.T.I.C. Art. 24.11, Sec. (f) (part).)

3 Sec. 651.156. TAKING OF INCOMPLETE PREMIUM FINANCE
4 AGREEMENT PROHIBITED. A license holder may not take a premium
5 finance agreement that has not been fully completed and executed at
6 the time the agreement is executed. (V.T.I.C. Art. 24.11, Sec. (f)
7 (part).)

8 Sec. 651.157. PERFECTION OF PREMIUM FINANCE AGREEMENT AS
9 SECURED TRANSACTION: FILING NOT REQUIRED. Filing of a premium
10 finance agreement or a financing statement is not necessary to
11 perfect the agreement as a secured transaction against a creditor,
12 subsequent purchaser, pledgee, encumbrancer, successor, or assign
13 of the insured or any other party. (V.T.I.C. Art. 24.14, Sec. (b).)

14 Sec. 651.158. PREPAYMENT AND REFUND. (a) Notwithstanding
15 the provisions of any premium finance agreement to the contrary, an
16 insured may pay the balance due under the agreement in full at any
17 time before the maturity of the final installment of the balance.

18 (b) If an insured pays a premium finance agreement in full
19 as authorized by this section and the agreement included an amount
20 for a charge, the insured is entitled to receive for the prepayment
21 by cash or renewal a refund credit in accordance with Subchapter H,
22 Chapter 342, Finance Code, and rules adopted under that subchapter.
23 If the amount of the credit for prepayment is less than \$1, the
24 insured is not entitled to a refund credit. (V.T.I.C. Art. 24.16.)

25 Sec. 651.159. DEFAULT CHARGE. A premium finance agreement
26 may provide for the payment of a default charge by the insured as
27 provided by Section 342.203, Finance Code, this code, or a rule

1 adopted under those statutes. (V.T.I.C. Art. 24.17, Sec. (a).)

2 Sec. 651.160. POWER OF ATTORNEY. A premium finance
3 agreement may contain a power of attorney that enables the
4 insurance premium finance company to cancel any or all of the
5 insurance contracts listed in the agreement as provided by Section
6 651.161. (V.T.I.C. Art. 24.17, Sec. (b) (part).)

7 Sec. 651.161. CANCELLATION OF INSURANCE CONTRACT. (a) An
8 insurance premium finance company may not cancel an insurance
9 contract listed in a premium finance agreement except as provided
10 by this section for an insured's failure to make a payment at the
11 time and in the amount provided in the agreement.

12 (b) The insurance premium finance company must mail to the
13 insured a written notice that the company will cancel the insurance
14 contract because of the insured's default in payment unless the
15 default is cured at or before the time stated in the notice. The
16 stated time may not be earlier than the 10th day after the date the
17 notice is mailed.

18 (c) The insurance premium finance company must also mail a
19 copy of the notice to the insurance agent or broker identified in
20 the premium finance agreement.

21 (d) After the time stated in the notice required by
22 Subsection (b), the insurance premium finance company may cancel
23 each applicable insurance contract by mailing a notice of
24 cancellation to the insurer. Each insurance contract shall be
25 canceled as if the insured had canceled the contract, except that
26 the return of a canceled contract is not required.

27 (e) The insurance premium finance company must also mail a

notice of cancellation to:

(1) the insured at the insured's last known address;
and

(2) the insurance agent or broker identified in the premium finance agreement.

(f) A statutory, regulatory, or contractual restriction that provides that an insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party applies to a cancellation under this section. The insurer shall:

(1) give the prescribed notice on behalf of the insurer or the insured to each governmental agency, mortgagee, or other third party on or before the second business day after the date the insurer receives the notice of cancellation from the insurance premium finance company; and

(2) determine the effective date of cancellation, taking into consideration the number of days' notice required to complete the cancellation. (V.T.I.C. Art. 24.17, Secs. (b) (part), (c), (d), (e).)

Sec. 651.162. RETURN OF UNEARNED PREMIUMS AND COMMISSIONS.

(a) This section applies only to a premium finance agreement that contains an assignment or power of attorney for the benefit of the insurance premium finance company.

(b) If an insurance contract listed in a premium finance agreement is canceled, the insurer shall return all unearned premiums that are due under the contract directly to the insurance premium finance company before the 61st day after the cancellation

1 date.

2 (c) The insurer may deduct from the unearned premiums
3 returned to the insurance premium finance company the amount of any
4 unearned commission due from the agent writing the insurance if the
5 insurer notifies the agent to return the unearned commission to the
6 insurance premium finance company. If the agent does not return the
7 unearned commission to the insurance premium finance company before
8 the 91st day after the cancellation date, the insurer shall remit
9 the unearned commission to the insurance premium finance company
10 before the 121st day after the cancellation date.

11 (d) Notwithstanding Subsections (a)-(c), an agent is liable
12 for the return of unearned commissions on an insurance contract
13 written through the Texas Windstorm Insurance Association, the
14 Texas Automobile Insurance Plan Association, or the Texas Medical
15 Liability Insurance Underwriting Association. An agent placing
16 business through one of those plans shall return the unearned
17 commissions to the insurance premium finance company before the
18 61st day after the date the agent is notified of the cancellation.

19 (e) An insurer, other than the Texas Windstorm Insurance
20 Association, the Texas Automobile Insurance Plan Association, or
21 the Texas Medical Liability Insurance Underwriting Association,
22 may return the unearned premiums to the producing agent. The
23 insurer remains liable and shall remit the unearned premiums to the
24 insurance premium finance company before the 121st day after the
25 cancellation date if:

26 (1) the producing agent does not return the unearned
27 premiums to the insurance premium finance company before the 91st

1 day after the cancellation date; and

2 (2) the insurance premium finance company complied
3 with Section 651.165.

4 (f) If the insurance premium finance company failed to
5 comply with Section 651.165, the insurer, including the Texas
6 Windstorm Insurance Association, the Texas Automobile Insurance
7 Plan Association, and the Texas Medical Liability Insurance
8 Underwriting Association, may comply with its legal duty to return
9 the unearned premiums due under the insurance contract to the
10 insurance premium finance company by returning those unearned
11 premiums to the producing agent.

12 (g) If the crediting of return premiums to the account of an
13 insured results in a surplus over the amount due from the insured,
14 the insurance premium finance company shall refund the excess to
15 the insured. If the amount of the excess is less than \$1, the
16 insured is not entitled to a refund. (V.T.I.C. Art. 24.17, Secs.
17 (f), (g).)

18 Sec. 651.163. ASSIGNMENT OF PREMIUM FINANCE AGREEMENT.
19 Unless the insured has notice of an actual or intended assignment of
20 a premium finance agreement, payment by an insured under the
21 agreement to the last known holder of the agreement is binding on
22 all subsequent holders or assignees. (V.T.I.C. Art. 24.18.)

23 Sec. 651.164. RESTRICTIONS ON PREMIUM FINANCE AGREEMENTS.
24 (a) A premium finance agreement may not contain any provision under
25 which, absent default by the insured, the insurance premium finance
26 company holding the agreement may arbitrarily or without reasonable
27 cause accelerate the maturity of all or any part of the amount owing

1 under the agreement.

2 (b) For purposes of Subsection (a), reasonable cause
3 includes a proceeding in bankruptcy, receivership, or insolvency
4 instituted by or against the insured or the insolvency of or
5 suspension of business or cessation of the right to engage in
6 business by an insurer writing policies that are financed for the
7 insured under the premium finance agreement.

8 (c) A license holder may not take:

9 (1) an instrument in which the insured waives any
10 right accruing to the insured under this chapter;

11 (2) an instrument that has not been fully completed
12 and executed by the insured;

13 (3) an assignment of wages as security for an
14 insurance premium finance agreement entered into under this
15 chapter;

16 (4) a lien on real property as security for a premium
17 finance agreement entered into under this chapter, except any lien
18 created by law on the recording of an abstract of judgment; or

19 (5) a confession of judgment or a power of attorney in
20 favor of the license holder or a third person to confess judgment or
21 to appear for an insured in a judicial proceeding. (V.T.I.C. Art.
22 24.19.)

23 Sec. 651.165. REQUIRED NOTICE OF CERTAIN PREMIUM FINANCE
24 AGREEMENTS. (a) An insurance premium finance company that enters
25 into a premium finance agreement that includes an assignment or
26 power of attorney shall notify the insurer or the Texas Windstorm
27 Insurance Association, the Texas Automobile Insurance Plan

1 Association, or the Texas Medical Liability Insurance Underwriting
2 Association whose premiums are being financed:

3 (1) of the existence of the agreement; and

4 (2) to whom the premium payment has been made.

5 (b) An insurance premium finance company shall notify and
6 fund all premiums to a county mutual insurance company unless the
7 insurance premium finance company is authorized in writing by the
8 county mutual insurance company to notify or fund an agent or
9 managing general agent.

10 (c) Notice required under this section must be made before
11 the 31st day after the date the premium finance agreement is
12 accepted by the insurance premium finance company. (V.T.I.C. Art.
13 24.22.)

14 Sec. 651.166. TAKING, RECEIVING, OR CHARGING UNAUTHORIZED
15 AMOUNT. (a) Taking or receiving from an insured or the charging of
16 an insured by an insurance premium finance company of a charge
17 greater than authorized by this chapter does not invalidate:

18 (1) the premium finance agreement; or

19 (2) the principal balance payable under the agreement.

20 (b) An action described by Subsection (a) may be adjudged a
21 forfeiture of all charges that:

22 (1) are authorized under the premium finance
23 agreement; or

24 (2) the insured has agreed to pay.

25 (c) A person who pays an unauthorized charge or the person's
26 legal representative may bring an action against the insurance
27 premium finance company to recover twice the total amount of the

1 charge paid. The action must be brought within two years after the
2 date the unauthorized charge is paid. (V.T.I.C. Art. 24.08, Sec.
3 (b).)

4 Sec. 651.167. EFFECT OF LICENSE REVOCATION, SUSPENSION, OR
5 SURRENDER ON PREMIUM FINANCE AGREEMENT. The revocation,
6 suspension, or surrender of a license does not affect the
7 obligation of an insured under a lawful premium finance agreement
8 previously acquired or held by the person whose license was
9 revoked, suspended, or surrendered. (V.T.I.C. Art. 24.05, Sec.
10 (d).)

11 [Sections 651.168-651.200 reserved for expansion]

12 SUBCHAPTER E. DISCIPLINARY PROCEDURES AND
13 PENALTIES; OFFENSES

14 Sec. 651.201. EXAMINATIONS AND INVESTIGATIONS OF LICENSE
15 HOLDERS. (a) The department may conduct an examination or
16 investigation that is necessary to determine whether a license
17 holder:

18 (1) is in compliance with this chapter; or
19 (2) has engaged in conduct that would warrant the
20 revocation or suspension of the license holder's license.

21 (b) The department or an authorized representative of the
22 department may:

23 (1) require the attendance of any person;
24 (2) examine the person under oath; and
25 (3) compel the production of any relevant book,
26 record, account, or document. (V.T.I.C. Art. 24.06, Sec. (a).)

27 Sec. 651.202. CONFIDENTIALITY OF REPORTS AND RELATED

1 MATERIAL. (a) A report of an examination or investigation under
2 Section 651.201 and any correspondence or memoranda concerning or
3 arising from the examination or investigation:

- 4 (1) are confidential communications;
5 (2) are not subject to subpoena; and
6 (3) may not be made public, except in connection with a
7 hearing under Section 651.204 or an appearance in connection with
8 the hearing.

9 (b) Subsection (a) applies to an authenticated copy of a
10 report described by Subsection (a) in the possession of the
11 commissioner, the department, or a license holder.

12 (c) Information obtained in the course of an examination or
13 investigation may be made available to another governmental agency
14 if the information involves a matter within the scope or
15 jurisdiction of the agency. (V.T.I.C. Art. 24.06, Sec. (b).)

16 Sec. 651.203. HEARINGS AND INVESTIGATIONS; SUBPOENA POWER.
17 In conducting a hearing or investigation under this chapter, the
18 department or a person designated by the department may:

- 19 (1) administer oaths;
20 (2) subpoena witnesses;
21 (3) take depositions of witnesses who reside outside
22 of this state in the manner provided for in a civil action in
23 district court; and
24 (4) pay to those witnesses a fee and mileage for
25 attendance as provided for a witness in a civil action in district
26 court. (V.T.I.C. Art. 24.07.)

27 Sec. 651.204. REVOCATION OR SUSPENSION OF LICENSE. After

1 notice and hearing, the department may revoke or suspend a license
2 if:

3 (1) the department finds:

4 (A) that the license holder has violated this
5 chapter or a rule adopted by the commissioner under this chapter; or

6 (B) the existence of a fact or condition that, if
7 the fact or condition existed at the time of the original
8 application for the license, clearly would have warranted the
9 refusal of the license; or

10 (2) the department learns from any source that the
11 license holder has failed to return all amounts due from an
12 insurance premium finance company to the person whose insurance
13 policy has been canceled as required by Section 651.162. (V.T.I.C.
14 Art. 24.05, Secs. (a), (b).)

15 Sec. 651.205. ISSUANCE OF REVOCATION OR SUSPENSION ORDER.
16 If the department revokes or suspends a license, the department
17 shall:

18 (1) immediately issue in duplicate a written order of
19 revocation or suspension;

20 (2) file one copy of the order in the office of the
21 secretary of state; and

22 (3) mail one copy of the order to the license holder.
23 (V.T.I.C. Art. 24.05, Sec. (e).)

24 Sec. 651.206. SURRENDER OF LICENSE; EFFECT. (a) A license
25 holder may surrender a license by delivering to the department
26 written notice that the license holder surrenders the license.

27 (b) The surrender of a license does not affect any civil or

1 criminal liability of the person for an act committed before the
2 surrender. (V.T.I.C. Art. 24.05, Sec. (c).)

3 Sec. 651.207. LICENSE REINSTATEMENT. The department may
4 reinstate a suspended license or issue a new license to a person
5 whose license has been revoked if no fact or condition exists that
6 clearly would have warranted the refusal to issue the license
7 originally. (V.T.I.C. Art. 24.05, Sec. (f).)

8 Sec. 651.208. OFFENSE. (a) A person commits an offense if
9 the person:

10 (1) intentionally, knowingly, recklessly, or
11 negligently engages in the operation of an insurance premium
12 finance company and does not hold a license issued under this
13 chapter;

14 (2) intentionally, knowingly, recklessly, or
15 negligently violates this chapter;

16 (3) intentionally or knowingly omits to state a
17 material fact necessary to give the commissioner or the department
18 information lawfully required of the person; or

19 (4) refuses to permit an investigation or examination
20 authorized under this chapter.

21 (b) An offense under this section is a Class B misdemeanor.
22 (V.T.I.C. Art. 24.08, Sec. (a).)

23 Sec. 651.209. SANCTIONS; CEASE AND DESIST ORDERS. In
24 addition to each penalty provided by Sections 651.166 and 651.208,
25 the commissioner or a person designated by the commissioner may:

26 (1) order a sanction under Subchapter B, Chapter 82;
27 or

(2) issue a cease and desist order under Chapter 83.
(V.T.I.C. Art. 24.08, Sec. (c).)

[Chapters 652-700 reserved for expansion]

SUBTITLE F. INSURANCE FRAUD

CHAPTER 701. INSURANCE FRAUD INVESTIGATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 701.001. DEFINITIONS

Sec. 701.002. BUSINESS OF INSURANCE

Sec. 701.003. EFFECT OF CHAPTER

[Sections 701.004-701.050 reserved for expansion]

SUBCHAPTER B. REPORTING FRAUDULENT INSURANCE ACTS

Sec. 701.051. DUTY TO REPORT

Sec. 701.052. IMMUNITY FOR FURNISHING INFORMATION

RELATING TO A FRAUDULENT INSURANCE

ACT

[Sections 701.053-701.100 reserved for expansion]

SUBCHAPTER C. INVESTIGATIONS

Sec. 701.101. INSURANCE FRAUD UNIT

Sec. 701.102. INVESTIGATION OF CERTAIN ACTS OF FRAUD

Sec. 701.103. DISCIPLINARY ACTION; REPORT TO OTHER

AGENCIES

Sec. 701.104. DEPARTMENT INVESTIGATORS

Sec. 701.105. ASSISTANCE FROM LAW ENFORCEMENT

Sec. 701.106. SUBPOENA AUTHORITY

Sec. 701.107. CERTAIN AGENCIES' DUTY TO PROVIDE

INFORMATION

Sec. 701.108. INSURER'S DUTY TO PROVIDE INFORMATION

1 Sec. 701.109. REQUEST FOR INVESTIGATION BY INSURER

2 [Sections 701.110-701.150 reserved for expansion]

3 SUBCHAPTER D. INSURANCE FRAUD INFORMATION;

4 CONFIDENTIALITY

5 Sec. 701.151. CONFIDENTIALITY OF DEPARTMENT INFORMATION

6 Sec. 701.152. CONFIDENTIALITY OF AUTHORIZED GOVERNMENTAL

7 AGENCY INFORMATION

8 Sec. 701.153. DISCLOSURE OF INFORMATION TO CERTAIN

9 AGENCIES

10 Sec. 701.154. DISCLOSURE OF INFORMATION TO PUBLIC

11 CHAPTER 701. INSURANCE FRAUD INVESTIGATIONS

12 SUBCHAPTER A. GENERAL PROVISIONS

13 Sec. 701.001. DEFINITIONS. In this chapter:

14 (1) "Authorized governmental agency" means:

15 (A) a municipal, county, or state law enforcement
16 agency of this state or another state or a law enforcement agency of
17 the United States; or

18 (B) the prosecuting attorney of a municipality,
19 county, or judicial district of this state or another state or the
20 prosecuting attorney of the United States.

21 (2) "Fraudulent insurance act" means an act that is a
22 violation of a penal law and is:

23 (A) committed or attempted while engaging in the
24 business of insurance;

25 (B) committed or attempted as part of or in
26 support of an insurance transaction; or

27 (C) part of an attempt to defraud an insurer.

1 (3) "Insurer" means a person who is engaged in the
2 business of insurance as a principal or agent. The term includes:

3 (A) an unauthorized insurer; and

4 (B) an entity that is self-insured and provides
5 health care benefits to the entity's employees.

6 (4) "Person" means an individual, corporation,
7 organization, governmental entity, business trust or another
8 trust, estate, partnership, joint venture, association, or any
9 other legal entity. (V.T.I.C. Art. 1.10D, Sec. 1(a).)

10 Sec. 701.002. BUSINESS OF INSURANCE. A person is engaged in
11 the business of insurance for purposes of this chapter if the person
12 performs any act described by Subchapter B, Chapter 101. (V.T.I.C.
13 Art. 1.10D, Sec. 1(b).)

14 Sec. 701.003. EFFECT OF CHAPTER. This chapter does not:

15 (1) preempt the authority or relieve the duty of an
16 authorized governmental agency to investigate and prosecute
17 suspected criminal acts;

18 (2) prevent or prohibit a person from voluntarily
19 disclosing information to an authorized governmental agency;

20 (3) limit powers or duties granted to the commissioner
21 by any other law; or

22 (4) prohibit or limit the authority of an insurer to
23 conduct an independent investigation of suspected insurance claim
24 fraud. (V.T.I.C. Art. 1.10D, Secs. 2(e) (part); 7.)

25 [Sections 701.004-701.050 reserved for expansion]

26 SUBCHAPTER B. REPORTING FRAUDULENT INSURANCE ACTS

27 Sec. 701.051. DUTY TO REPORT. (a) A person who determines

1 a fraudulent insurance act has been or is about to be committed
2 shall report the information in writing to the department or an
3 authorized governmental agency not later than the 30th day after
4 the date the person makes the determination.

5 (b) A report made to one authorized governmental agency or
6 the department constitutes notice to each other authorized
7 governmental agency and the department. (V.T.I.C. Art. 1.10D,
8 Secs. 4(a), (b).)

9 Sec. 701.052. IMMUNITY FOR FURNISHING INFORMATION RELATING
10 TO A FRAUDULENT INSURANCE ACT. (a) A person is not liable in a
11 civil action, including an action for libel or slander, and a civil
12 action may not be brought against the person, for furnishing
13 information relating to a suspected, anticipated, or completed
14 fraudulent insurance act if the information is provided to:

15 (1) an authorized governmental agency or the
16 department;

17 (2) a law enforcement officer or an agent or employee
18 of the officer;

19 (3) the National Association of Insurance
20 Commissioners or an employee of the association;

21 (4) a state or federal governmental agency established
22 to detect and prevent fraudulent insurance acts or to regulate the
23 business of insurance or an employee of the agency; or

24 (5) a special investigative unit of an insurer,
25 including a person who contracts to provide special investigative
26 unit services to the insurer or an employee of the insurer who is
27 responsible for the investigation of suspected fraudulent

1 insurance acts.

2 (b) A person may furnish information as described in
3 Subsection (a) orally or in writing, including through publishing,
4 disseminating, or filing a bulletin or report.

5 (c) Subsection (a) does not apply to a person who acts with
6 malice, fraudulent intent, or bad faith.

7 (d) A person to whom Subsection (a) applies who prevails in
8 a civil action arising from furnishing information as described in
9 Subsection (a) is entitled to attorney's fees and costs.

10 (e) This section does not affect any common law or statutory
11 privilege or immunity.

12 (f) An insurer shall exercise reasonable care concerning
13 the accuracy of information conveyed to an authorized governmental
14 agency, the insurance fraud unit, or another insurer, person, or
15 entity. (V.T.I.C. Art. 1.10D, Secs. 6(a), (b), (c), (d), (e)
16 (part).)

17 [Sections 701.053-701.100 reserved for expansion]

18 SUBCHAPTER C. INVESTIGATIONS

19 Sec. 701.101. INSURANCE FRAUD UNIT. (a) The purpose of the
20 department's insurance fraud unit is to enforce laws relating to
21 fraudulent insurance acts.

22 (b) The insurance fraud unit may receive, review, and
23 investigate in a timely manner insurer antifraud reports submitted
24 under Chapter 704.

25 (c) The insurance fraud unit shall report annually to the
26 commissioner in writing regarding:

27 (1) the number of cases completed by the insurance

1 fraud unit; and

2 (2) recommendations for regulatory and statutory
3 responses to the types of fraudulent activities encountered by the
4 insurance fraud unit. (V.T.I.C. Art. 1.10D, Secs. 2(a); 3A.)

5 Sec. 701.102. INVESTIGATION OF CERTAIN ACTS OF FRAUD. If
6 the commissioner has reason to believe a person has engaged in, is
7 engaging in, has committed, or is about to commit a fraudulent
8 insurance act or the offense of insurance fraud under Section
9 35.02(a), Penal Code, the commissioner may conduct any
10 investigation necessary inside or outside this state to:

11 (1) determine whether the act or offense occurred; or

12 (2) aid in enforcing laws relating to fraudulent
13 insurance acts or insurance fraud. (V.T.I.C. Art. 1.10D, Sec.
14 2(b).)

15 Sec. 701.103. DISCIPLINARY ACTION; REPORT TO OTHER
16 AGENCIES. (a) The commissioner shall take appropriate
17 disciplinary action as provided by this code if the commissioner
18 believes a fraudulent insurance act has occurred. The commissioner
19 shall report information concerning the commissioner's belief that
20 a person has committed a fraudulent insurance act to an authorized
21 governmental agency.

22 (b) The commissioner shall:

23 (1) provide all material, documents, reports,
24 complaints, or other evidence to an authorized governmental agency
25 on request; and

26 (2) assist the authorized governmental agency as
27 requested. (V.T.I.C. Art. 1.10D, Secs. 2(c), (d).)

1 Sec. 701.104. DEPARTMENT INVESTIGATORS. (a) The
2 commissioner may:

3 (1) employ investigators as necessary to enforce this
4 chapter; and

5 (2) commission those investigators as peace officers.

6 (b) If the commissioner commissions investigators as peace
7 officers, the commissioner shall appoint a chief investigator who:

8 (1) is commissioned as a peace officer; and

9 (2) is qualified by training and experience in law
10 enforcement to supervise, direct, and administer the activities of
11 the commissioned investigators.

12 (c) An investigator employed by the department as a peace
13 officer must meet the requirements for a peace officer under
14 Chapter 1701, Occupations Code. (V.T.I.C. Art. 1.10D, Sec. 2(f).)

15 Sec. 701.105. ASSISTANCE FROM LAW ENFORCEMENT. An
16 investigator employed by the department may request assistance from
17 local law enforcement officers in conducting an investigation
18 authorized by this chapter. (V.T.I.C. Art. 1.10D, Sec. 2(g).)

19 Sec. 701.106. SUBPOENA AUTHORITY. (a) The commissioner
20 may issue a subpoena to compel the attendance and testimony of a
21 witness or, except as provided by Subsection (b), the production of
22 materials relevant to an investigation under this chapter.

23 (b) A person is not required to produce an item subpoenaed
24 under Subsection (a) if the item can only be identified by writing
25 and executing a special computer program for that purpose.

26 (c) A person possessing materials located outside this
27 state that are requested by the commissioner may make the materials

1 available to the commissioner or a representative of the
2 commissioner for examination at the place where the materials are
3 located. The commissioner may designate a representative,
4 including an official of the state in which the materials are
5 located, to examine the materials. The commissioner may respond to
6 a similar request from an official of another state or the United
7 States. (V.T.I.C. Art. 1.10D, Secs. 3(a), (b).)

8 Sec. 701.107. CERTAIN AGENCIES' DUTY TO PROVIDE
9 INFORMATION. (a) On the insurance fraud unit's request, an
10 authorized governmental agency or a state licensing agency shall
11 provide material, documents, reports, complaints, or other
12 evidence to the insurance fraud unit.

13 (b) Compliance with Subsection (a) by an authorized
14 governmental agency or a state licensing agency does not constitute
15 waiver of any otherwise applicable privilege or confidentiality
16 requirement. (V.T.I.C. Art. 1.10D, Sec. 2(d-1) (part).)

17 Sec. 701.108. INSURER'S DUTY TO PROVIDE INFORMATION. On
18 the written request of an authorized governmental agency, an
19 insurer shall provide to the agency any relevant information or
20 material relating to a matter under investigation. (V.T.I.C. Art.
21 1.10D, Sec. 4(c).)

22 Sec. 701.109. REQUEST FOR INVESTIGATION BY INSURER. An
23 insurer must complete an investigation of suspected insurance claim
24 fraud and draft a report of the insurer's findings before
25 requesting that the commissioner conduct an investigation. The
26 insurer must submit the report and the related investigation file
27 to the commissioner as part of the insurer's request that the

1 commissioner conduct an investigation. (V.T.I.C. Art. 1.10D, Sec.
2 2(e) (part).)

3 [Sections 701.110-701.150 reserved for expansion]

4 SUBCHAPTER D. INSURANCE FRAUD INFORMATION;

5 CONFIDENTIALITY

6 Sec. 701.151. CONFIDENTIALITY OF DEPARTMENT INFORMATION.

7 (a) Information or material acquired by the department that is
8 relevant to an investigation by the insurance fraud unit is not a
9 public record for the period the commissioner considers reasonably
10 necessary to:

11 (1) complete the investigation;

12 (2) protect the person under investigation from
13 unwarranted injury; or

14 (3) serve the public interest.

15 (b) The information or material is not subject to a subpoena
16 by another governmental entity, other than a grand jury subpoena,
17 until:

18 (1) the information or material is released for public
19 inspection by the commissioner; or

20 (2) after notice and a hearing a district court
21 determines that obeying the subpoena would not jeopardize the
22 public interest and any investigation by the commissioner.

23 (c) This section does not affect the conduct of a contested
24 case under Chapter 2001, Government Code. (V.T.I.C. Art. 1.10D,
25 Sec. 5(a).)

26 Sec. 701.152. CONFIDENTIALITY OF AUTHORIZED GOVERNMENTAL
27 AGENCY INFORMATION. Information or material acquired under this

1 chapter by an authorized governmental agency is privileged and is
2 not a public record. The information or material is not subject to a
3 subpoena, other than a grand jury subpoena, unless, after
4 reasonable notice to the insurer and agency and a hearing, a
5 district court determines that obeying the subpoena would not
6 jeopardize the public interest and any investigation by the agency.
7 (V.T.I.C. Art. 1.10D, Sec. 5(b) (part).)

8 Sec. 701.153. DISCLOSURE OF INFORMATION TO CERTAIN
9 AGENCIES. An authorized governmental agency may release to another
10 authorized governmental agency or the department and the department
11 may release to an authorized governmental agency information or
12 material provided under this chapter. (V.T.I.C. Art. 1.10D, Sec.
13 5(c).)

14 Sec. 701.154. DISCLOSURE OF INFORMATION TO PUBLIC. (a)
15 Except as otherwise provided by law, an authorized governmental
16 agency or an insurer that possesses or receives information or
17 material under this chapter may not release that information or
18 material to the public.

19 (b) Information provided under this chapter by an insurer to
20 the insurance fraud unit or an authorized governmental agency is
21 not subject to public disclosure. The information may be used by
22 the insurance fraud unit or authorized governmental agency only in
23 performing duties described by this chapter.

24 (c) Notwithstanding Section 701.151, the commissioner may
25 not release evidence obtained under Section 701.107 for public
26 inspection if releasing the evidence would violate a privilege held
27 by or a confidentiality requirement imposed on the agency from

which the evidence was obtained. (V.T.I.C. Art. 1.10D, Secs. 2(d-1) (part); 5(b) (part); 6(e) (part).)

CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR

VEHICLE INSURANCE FRAUD REPORTING

Sec. 702.001. DEFINITIONS

Sec. 702.002. INSURER'S DUTY TO PROVIDE INFORMATION

Sec. 702.003. INSURER'S DUTY TO NOTIFY GOVERNMENTAL

AGENCY

Sec. 702.004. DISCLOSURE OF INFORMATION TO CERTAIN

AGENCIES

Sec. 702.005. INFORMATION PRIVILEGED

Sec. 702.006. IMMUNITY FOR PROVIDING INFORMATION

CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR

VEHICLE INSURANCE FRAUD REPORTING

Sec. 702.001. DEFINITIONS. In this chapter:

(1) "Authorized governmental agency" means:

(A) the Department of Public Safety;

(B) a police department of a municipality;

(C) a sheriff's department;

(D) a criminal investigative department or agency of the United States; or

(E) the prosecuting attorney of:

(i) a municipality, judicial district, or county of this state;

(ii) the United States; or

(iii) a judicial district of the United States.

1 (2) "Insurer" means an insurer that is:

2 (A) authorized to write motor vehicle insurance
3 in this state; or

4 (B) liable for a loss due to motor vehicle theft
5 or motor vehicle insurance fraud. (V.T.I.C. Art. 21.78, Sec. 1.)

6 Sec. 702.002. INSURER'S DUTY TO PROVIDE INFORMATION. (a)
7 On the written request of an authorized governmental agency to an
8 insurer, the insurer or an agent authorized by the insurer to act on
9 the insurer's behalf shall release to the agency any relevant
10 information the insurer has that:

11 (1) is requested by the agency; and

12 (2) relates to a specific motor vehicle theft or motor
13 vehicle insurance fraud.

14 (b) In this section, relevant information includes:

15 (1) insurance policy information relevant to the
16 specific motor vehicle theft or motor vehicle insurance fraud under
17 investigation, including any application for the policy;

18 (2) available policy premium payment records;

19 (3) the history of previous claims made by the
20 insured; and

21 (4) information relating to the investigation of the
22 motor vehicle theft or motor vehicle insurance fraud, including
23 statements of any person, proofs of loss, and notices of loss.
24 (V.T.I.C. Art. 21.78, Sec. 2(a).)

25 Sec. 702.003. INSURER'S DUTY TO NOTIFY GOVERNMENTAL AGENCY.

26 (a) An insurer or an agent authorized by an insurer to act on the
27 insurer's behalf shall notify an authorized governmental agency if

1 it:

2 (1) knows or reasonably believes it knows the identity
3 of a person who it has reason to believe committed a criminal or
4 fraudulent act relating to a motor vehicle theft or motor vehicle
5 insurance claim; or

6 (2) knows of a criminal fraudulent act relating to a
7 motor vehicle theft or motor vehicle insurance claim that it
8 reasonably believes has not been reported to an authorized
9 governmental agency.

10 (b) Notice provided under this section to one authorized
11 governmental agency is sufficient notice to each other authorized
12 governmental agency. This subsection does not affect the rights
13 and duties created under Section 702.002. (V.T.I.C. Art. 21.78,
14 Secs. 2(b), (c).)

15 Sec. 702.004. DISCLOSURE OF INFORMATION TO CERTAIN
16 AGENCIES. An authorized governmental agency provided information
17 under Section 702.002 or 702.003 may provide the information to
18 another authorized governmental agency. (V.T.I.C. Art. 21.78, Sec.
19 2(d).)

20 Sec. 702.005. INFORMATION PRIVILEGED. (a) Information
21 provided under this chapter is privileged and is not a public
22 record. Except as otherwise provided by law, an entity that
23 receives information provided under this chapter may not release
24 the information to the public.

25 (b) Evidence or information provided under this chapter is
26 not subject to a subpoena ad testificandum or a subpoena duces tecum
27 in a civil or criminal proceeding unless, after reasonable notice

1 to an insurer, agent authorized by an insurer to act on the
2 insurer's behalf, or authorized governmental agency that has an
3 interest in the information and after a hearing, a court determines
4 that obeying the subpoena would not jeopardize the public interest
5 and any ongoing investigation by the insurer, agent, or authorized
6 governmental agency. (V.T.I.C. Art. 21.78, Sec. 3.)

7 Sec. 702.006. IMMUNITY FOR PROVIDING INFORMATION. (a) An
8 insurer or a person who provides information on an insurer's behalf
9 is not liable for damages in a civil action or subject to criminal
10 prosecution for oral or written statements made or any other action
11 taken necessary to provide information as required by this chapter.

12 (b) Subsection (a) does not apply to an insurer or person
13 who acts with malice or fraudulent intent. (V.T.I.C. Art. 21.78,
14 Sec. 4.)

15 CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

16 SUBCHAPTER A. GENERAL PROVISIONS

17 Sec. 703.001. DEFINITION

18 Sec. 703.002. RIGHT OF INTERVENTION

19 [Sections 703.003-703.050 reserved for expansion]

20 SUBCHAPTER B. ANTIFRAUD ACTION; CERTIFICATION

21 Sec. 703.051. ANTIFRAUD ACTION AUTHORIZED

22 Sec. 703.052. REQUEST FOR CERTIFICATION

23 Sec. 703.053. NOTICE OF REQUEST FOR CERTIFICATION

24 Sec. 703.054. HEARING ON REQUEST FOR CERTIFICATION

25 Sec. 703.055. CERTIFICATION

26 [Sections 703.056-703.100 reserved for expansion]

27 SUBCHAPTER C. EXPENSES OF ANTIFRAUD ACTION

1 Sec. 703.101. DETERMINATION OF EXPENSES

2 Sec. 703.102. DEDUCTION OR OFFSET FOR EXPENSES;

3 REIMBURSEMENT

4 Sec. 703.103. ASSIGNMENT OF DEDUCTION OR OFFSET

5 Sec. 703.104. TREATMENT OF DEDUCTION OR OFFSET

6 AS ADMITTED ASSET

7 CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

8 SUBCHAPTER A. GENERAL PROVISIONS

9 Sec. 703.001. DEFINITION. In this chapter, "covered
10 entity" means a health maintenance organization or insurer
11 regulated by the department, including:

12 (1) a stock life, health, or accident insurance
13 company;

14 (2) a mutual life, health, or accident insurance
15 company;

16 (3) a stock fire or casualty insurance company;

17 (4) a mutual fire or casualty insurance company;

18 (5) a Mexican casualty insurance company;

19 (6) a Lloyd's plan;

20 (7) a reciprocal or interinsurance exchange;

21 (8) a fraternal benefit society;

22 (9) a title insurance company;

23 (10) an attorney's title insurance company;

24 (11) a stipulated premium company;

25 (12) a nonprofit legal services corporation;

26 (13) a statewide mutual assessment company;

27 (14) a local mutual aid association;

- (15) a local mutual burial association;
- (16) an association exempt under Section 887.102;
- (17) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;
- (18) a county mutual insurance company; and
- (19) a farm mutual insurance company. (V.T.I.C. Art. 21.79D, Sec. 1(2).)

Sec. 703.002. RIGHT OF INTERVENTION. This chapter does not affect the right of any person, including a state agency, to intervene in an antifraud action brought under this chapter. (V.T.I.C. Art. 21.79D, Sec. 6.)

[Sections 703.003-703.050 reserved for expansion]

SUBCHAPTER B. ANTIFRAUD ACTION; CERTIFICATION

Sec. 703.051. ANTIFRAUD ACTION AUTHORIZED. (a) A covered entity acting alone or through a person, corporation, or legal entity affiliated with the covered entity may bring an action in a court, including a counter-action or cross-action, to:

(1) prevent a person from fraudulently engaging in the business of insurance or the business of a health maintenance organization in this state; or

(2) redress the effects of a person who has fraudulently engaged in the business of insurance or the business of a health maintenance organization in this state.

(b) An action may be brought under this section if:

(1) the acts of the person may adversely affect or have adversely affected at least 10 residents of this state; and

(2) the department has not brought an antifraud action

1 in a court against the person.

2 (c) An action may be brought under this section regardless
3 of whether the covered entity is directly affected by the person's
4 acts. (V.T.I.C. Art. 21.79D, Sec. 2.)

5 Sec. 703.052. REQUEST FOR CERTIFICATION. A covered entity
6 may request the court to certify that the action is an antifraud
7 action under this chapter. (V.T.I.C. Art. 21.79D, Sec. 3(a).)

8 Sec. 703.053. NOTICE OF REQUEST FOR CERTIFICATION. (a)
9 When a covered entity files a request for certification, the
10 covered entity shall provide at least 10 days' notice of the request
11 to the department and the attorney general by serving each with a
12 copy of the request in the manner provided for service of notice
13 under Rule 21a, Texas Rules of Civil Procedure.

14 (b) The covered entity shall provide the notice regardless
15 of whether the department or the state is a party to the action.
16 (V.T.I.C. Art. 21.79D, Sec. 3(b).)

17 Sec. 703.054. HEARING ON REQUEST FOR CERTIFICATION. As
18 soon as practicable after a covered entity files a request for
19 certification, the court shall hold a hearing to determine whether
20 the action is an antifraud action under this chapter. (V.T.I.C.
21 Art. 21.79D, Sec. 3(c).)

22 Sec. 703.055. CERTIFICATION. The court shall certify that
23 the action is an antifraud action if the court determines that:

- 24 (1) the requirements of Section 703.051 are met; and
25 (2) the pleadings and evidence demonstrate that the
26 covered entity has a probable right of recovery. (V.T.I.C. Art.
27 21.79D, Sec. 3(d).)

[Sections 703.056-703.100 reserved for expansion]

SUBCHAPTER C. EXPENSES OF ANTIFRAUD ACTION

Sec. 703.101. DETERMINATION OF EXPENSES. (a) The court that certifies an action as an antifraud action by order may determine the amount of reasonable and necessary expenses incurred in bringing the action, including court costs, reasonable attorney's fees, witness fees, fees of experts, and deposition expenses.

(b) In making the determination, the court may consider the contribution to the action of any person, including a state agency, that has intervened in the action. (V.T.I.C. Art. 21.79D, Sec. 4.)

Sec. 703.102. DEDUCTION OR OFFSET FOR EXPENSES; REIMBURSEMENT. (a) Subject to Subsection (b), a covered entity has a deduction or offset against any obligation, assessment, or debt owed by the covered entity to this state in the amount of the reasonable and necessary expenses determined by the court order.

(b) The covered entity shall reimburse the state the amount of any expenses actually recovered from the parties to the private antifraud action under a final judgment awarding, wholly or partly, expenses to or for the covered entity's benefit. The amount of reimbursement may not exceed the actual amount of deductions or offsets taken by the covered entity. (V.T.I.C. Art. 21.79D, Sec. 5(a) (part).)

Sec. 703.103. ASSIGNMENT OF DEDUCTION OR OFFSET. The covered entity may assign the covered entity's deduction or offset to any other covered entity or reinsurer. (V.T.I.C. Art. 21.79D, Sec. 5(a) (part).)

1 Sec. 703.104. TREATMENT OF DEDUCTION OR OFFSET AS ADMITTED
2 ASSET. A covered entity or a covered entity's assignee entitled to
3 an offset or deduction that has not been used may show, in the
4 covered entity's or assignee's books and records, the balance of the
5 deduction or offset as an admitted asset for any purpose. (V.T.I.C.
6 Art. 21.79D, Sec. 5(b).)

7 CHAPTER 704. ANTIFRAUD PROGRAMS

8 SUBCHAPTER A. GENERAL PROVISIONS

9 Sec. 704.001. DEFINITION

10 Sec. 704.002. NOTICE RELATING TO FALSE OR FRAUDULENT

11 CLAIMS REQUIRED

12 [Sections 704.003-704.050 reserved for expansion]

13 SUBCHAPTER B. ANTIFRAUD PLANS

14 Sec. 704.051. ANTIFRAUD PLAN REQUIRED FOR CERTAIN PLAN

15 ISSUERS

16 Sec. 704.052. ANTIFRAUD PLAN REQUIREMENTS

17 Sec. 704.053. FILING OF ANTIFRAUD PLAN

18 Sec. 704.054. FRAUD AND ABUSE PLANS UNDER CERTAIN STATE

19 PROGRAMS; ENFORCEMENT

20 CHAPTER 704. ANTIFRAUD PROGRAMS

21 SUBCHAPTER A. GENERAL PROVISIONS

22 Sec. 704.001. DEFINITION. In this chapter, "plan issuer"
23 means:

24 (1) a health insurer, including a life, health, and
25 accident insurer, a health and accident insurer, a health
26 maintenance organization, and any other person operating under
27 Chapter 841, 842, 843, 884, 885, 982, or 1501 who is authorized to

1 issue, issue for delivery, or deliver insurance policies,
2 certificates, contracts, or evidences of coverage in this state;

3 (2) an approved nonprofit health corporation that
4 holds a certificate of authority issued under Chapter 844; or

5 (3) an insurer authorized by the department to write
6 workers' compensation insurance in this state. (V.T.I.C. Art.
7 3.97-1, Subdiv. (2).)

8 Sec. 704.002. NOTICE RELATING TO FALSE OR FRAUDULENT CLAIMS
9 REQUIRED. (a) A plan issuer who provides a form for a person to
10 make a claim against or to give notice of the person's intent to
11 make a claim against a policy, certificate, contract, or evidence
12 of coverage issued by the issuer must include on the form, in
13 comparative prominence with the other content on the form, a
14 statement that is substantially similar to the following: "Any
15 person who knowingly presents a false or fraudulent claim for the
16 payment of a loss is guilty of a crime and may be subject to fines
17 and confinement in state prison."

18 (b) This section does not apply to a form provided to make a
19 claim against a policy issued by a reinsurer. (V.T.I.C. Art.
20 3.97-2.)

21 [Sections 704.003-704.050 reserved for expansion]

22 SUBCHAPTER B. ANTIFRAUD PLANS

23 Sec. 704.051. ANTIFRAUD PLAN REQUIRED FOR CERTAIN PLAN
24 ISSUERS. A plan issuer who collects direct written premium shall
25 adopt an antifraud plan under this subchapter. (V.T.I.C. Art.
26 3.97-3, Sec. (a) (part).)

27 Sec. 704.052. ANTIFRAUD PLAN REQUIREMENTS. An antifraud

1 plan adopted by a plan issuer under this subchapter must include a
2 description of the issuer's procedures for:

3 (1) detecting and investigating possible fraudulent
4 insurance acts; and

5 (2) reporting possible fraudulent insurance acts to
6 the insurance fraud unit. (V.T.I.C. Art. 3.97-3, Sec. (a) (part).)

7 Sec. 704.053. FILING OF ANTIFRAUD PLAN. A plan issuer may
8 annually file the issuer's antifraud plan adopted under this
9 subchapter with the insurance fraud unit. (V.T.I.C. Art. 3.97-3,
10 Sec. (a) (part).)

11 Sec. 704.054. FRAUD AND ABUSE PLANS UNDER CERTAIN STATE
12 PROGRAMS; ENFORCEMENT. (a) A fraud and abuse plan put in place by a
13 plan issuer participating in the Medicaid STAR or STAR + Plus
14 program or the child health plan program under Chapter 62, Health
15 and Safety Code, and approved by a health and human services agency
16 meets the requirements of this subchapter.

17 (b) If a plan issuer described by Subsection (a) is required
18 by law to report possible fraudulent insurance acts to a health and
19 human services agency or the office of the attorney general, the
20 issuer is not required to report those acts to the insurance fraud
21 unit.

22 (c) The insurance fraud unit, the office of the attorney
23 general, and the health and human services agencies shall
24 coordinate enforcement efforts with respect to fraudulent
25 insurance acts covered by this chapter relating to the Medicaid
26 program or the child health plan program. (V.T.I.C. Art. 3.97-3,
27 Secs. (b), (c).)

CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 705.001. DEFINITION

Sec. 705.002. APPLICABILITY OF SUBCHAPTER

Sec. 705.003. POLICY PROVISION: MISREPRESENTATION IN PROOF
OF LOSS OR DEATH

Sec. 705.004. POLICY PROVISION: MISREPRESENTATION IN
POLICY APPLICATION

Sec. 705.005. NOTICE TO INSURED OF MISREPRESENTATIONS

[Sections 705.006-705.050 reserved for expansion]

SUBCHAPTER B. SPECIAL PROVISIONS RELATED TO LIFE,
ACCIDENT, AND HEALTH INSURANCE POLICIES

Sec. 705.051. IMMATERIAL MISREPRESENTATION IN LIFE, ACCIDENT,
OR HEALTH INSURANCE APPLICATION

[Sections 705.052-705.100 reserved for expansion]

SUBCHAPTER C. SPECIAL PROVISIONS RELATED TO
LIFE INSURANCE POLICIES

Sec. 705.101. DEFINITION

Sec. 705.102. APPLICABILITY OF SUBCHAPTER

Sec. 705.103. DOCUMENTS TO ACCOMPANY POLICY

Sec. 705.104. MISREPRESENTATION IN APPLICATION FOR
LIFE INSURANCE

Sec. 705.105. APPLICABILITY OF OTHER LAW

CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 705.001. DEFINITION. In this subchapter, "insurance
policy" means a contract or policy of insurance. (V.T.I.C. Arts.

1 21.16 (part), 21.17 (part), 21.19 (part).)

2 Sec. 705.002. APPLICABILITY OF SUBCHAPTER. Except as
3 provided by Section 705.005, this subchapter applies to each
4 insurance policy issued or contracted for in this state. (V.T.I.C.
5 Arts. 21.16 (part), 21.17 (part), 21.19 (part).)

6 Sec. 705.003. POLICY PROVISION: MISREPRESENTATION IN PROOF
7 OF LOSS OR DEATH. (a) An insurance policy provision that states
8 that a misrepresentation, including a false statement, made in a
9 proof of loss or death makes the policy void or voidable:

10 (1) has no effect; and

11 (2) is not a defense in a suit brought on the policy.

12 (b) Subsection (a) does not apply if it is shown at trial
13 that the misrepresentation:

14 (1) was fraudulently made;

15 (2) misrepresented a fact material to the question of
16 the insurer's liability under the policy; and

17 (3) misled the insurer and caused the insurer to waive
18 or lose a valid defense to the policy. (V.T.I.C. Art. 21.19
19 (part).)

20 Sec. 705.004. POLICY PROVISION: MISREPRESENTATION IN
21 POLICY APPLICATION. (a) An insurance policy provision that states
22 that false statements made in the application for the policy or in
23 the policy make the policy void or voidable:

24 (1) has no effect; and

25 (2) is not a defense in a suit brought on the policy.

26 (b) Subsection (a) does not apply if it is shown at trial
27 that the matter misrepresented:

1 (1) was material to the risk; or

2 (2) contributed to the contingency or event on which
3 the policy became due and payable.

4 (c) It is a question of fact whether a misrepresentation
5 made in the application for the policy or in the policy itself was
6 material to the risk or contributed to the contingency or event on
7 which the policy became due and payable. (V.T.I.C. Art. 21.16
8 (part).)

9 Sec. 705.005. NOTICE TO INSURED OF MISREPRESENTATIONS. (a)
10 This section applies to any suit brought on an insurance policy
11 issued or contracted for after June 29, 1903.

12 (b) A defendant may use as a defense a misrepresentation
13 made in the application for or in obtaining an insurance policy only
14 if the defendant shows at trial that before the 91st day after the
15 date the defendant discovered the falsity of the representation,
16 the defendant gave notice that the defendant refused to be bound by
17 the policy:

18 (1) to the insured, if living; or

19 (2) to the owners or beneficiaries of the insurance
20 policy, if the insured was deceased.

21 (c) This section does not:

22 (1) make available as a defense an immaterial
23 misrepresentation; or

24 (2) affect the provisions of Section 705.004.
25 (V.T.I.C. Art. 21.17 (part).)

26 [Sections 705.006-705.050 reserved for expansion]

27 SUBCHAPTER B. SPECIAL PROVISIONS RELATED TO LIFE,

ACCIDENT, AND HEALTH INSURANCE POLICIES

Sec. 705.051. IMMATERIAL MISREPRESENTATION IN LIFE, ACCIDENT, OR HEALTH INSURANCE APPLICATION. A misrepresentation in an application for a life, accident, or health insurance policy does not defeat recovery under the policy unless the misrepresentation:

(1) is of a material fact; and

(2) affects the risks assumed. (V.T.I.C. Art. 21.18.)

[Sections 705.052-705.100 reserved for expansion]

SUBCHAPTER C. SPECIAL PROVISIONS RELATED TO LIFE

INSURANCE POLICIES

Sec. 705.101. DEFINITION. In this subchapter, "insurance policy" means a contract or policy of insurance. (V.T.I.C. Art. 21.35 (part).)

Sec. 705.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurance policy issued or contracted for in this state. (V.T.I.C. Art. 21.35 (part).)

Sec. 705.103. DOCUMENTS TO ACCOMPANY POLICY. Except as otherwise provided by this code, a life insurance policy must be accompanied by a copy of:

(1) the policy application; and

(2) any questions and answers given in connection with the application. (V.T.I.C. Art. 21.35 (part).)

Sec. 705.104. MISREPRESENTATION IN APPLICATION FOR LIFE INSURANCE. A defense based on a misrepresentation in the application for, or in obtaining, a life insurance policy on the life of a person in or residing in this state is not valid or

1 enforceable in a suit brought on the policy on or after the second
2 anniversary of the date of issuance of the policy if premiums due on
3 the policy during the two years have been paid to and received by
4 the insurer, unless:

5 (1) the insurer has notified the insured of the
6 insurer's intention to rescind the policy because of the
7 misrepresentation; or

8 (2) it is shown at the trial that the
9 misrepresentation was:

10 (A) material to the risk; and

11 (B) intentionally made. (V.T.I.C. Art. 21.35
12 (part).)

13 Sec. 705.105. APPLICABILITY OF OTHER LAW. Subchapter A
14 does not apply to a life insurance policy:

15 (1) that contains a provision making the policy
16 incontestable after two years or less; and

17 (2) on which premiums have been duly paid. (V.T.I.C.
18 Art. 21.35 (part).)

19 SECTION 3. SUBTITLES A-G, TITLE 8, INSURANCE CODE. Title 8,
20 Insurance Code, is amended by adding Subtitles A-G to read as
21 follows:

22 SUBTITLE A. HEALTH COVERAGE IN GENERAL

23 CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE

24 CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES

25 IN GENERAL

26 CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

27 CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH

AND ACCIDENT INSURANCE POLICY OR PLAN

BENEFITS

CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT

BASED ON EXISTING COVERAGE PROHIBITED

CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS

AND CHILDREN ELIGIBLE FOR STATE CHILD

HEALTH PLAN

CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH

BENEFIT PLAN ISSUER

CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION

CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

[Chapters 1211-1250 reserved for expansion]

SUBTITLE B. GROUP HEALTH COVERAGE

CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE

CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP

AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN CERTAIN

CIRCUMSTANCES

CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH AND

ACCIDENT COVERAGE

[Chapters 1255-1270 reserved for expansion]

SUBTITLE C. MANAGED CARE

CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE

ORGANIZATIONS; EVIDENCE OF COVERAGE;

CHARGES

CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH

MAINTENANCE ORGANIZATION

CHAPTER 1273. POINT-OF-SERVICE PLANS

[Chapters 1274-1300 reserved for expansion]

SUBTITLE D. PREFERRED PROVIDER BENEFIT PLANS

CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

[Chapters 1302-1350 reserved for expansion]

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1351. HOME HEALTH SERVICES

CHAPTER 1352. BRAIN INJURY

CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS UNDER

MANAGED CARE PLANS

CHAPTER 1354. ELIGIBILITY FOR BENEFITS FOR ALZHEIMER'S

DISEASE

CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

CHAPTER 1357. MASTECTOMY

CHAPTER 1358. DIABETES

CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH PHENYLKETONURIA

OR OTHER HERITABLE DISEASES

CHAPTER 1360. DIAGNOSIS AND TREATMENT AFFECTING

TEMPOROMANDIBULAR JOINT

CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL

CANCER

CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS, OR

HIV-RELATED ILLNESSES

1 CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

2 CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

3 CHAPTER 1367. COVERAGE OF CHILDREN

4 CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

5 CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS AND

6 DEVICES AND RELATED SERVICES

7 [Chapters 1370-1450 reserved for expansion]

8 SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

9 CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND

10 FACILITIES

11 CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

12 CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES UNDER

13 MANAGED CARE PLAN

14 CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

15 CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

16 [Chapters 1456-1500 reserved for expansion]

17 SUBTITLE G. HEALTH COVERAGE AVAILABILITY

18 CHAPTER 1501. HEALTH INSURANCE PORTABILITY AND AVAILABILITY

19 ACT

20 CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

21 CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

22 CHAPTER 1504. MEDICAL CHILD SUPPORT

23 CHAPTER 1505. GROUP INSURANCE PLANS FOR PERSONS 65 YEARS

24 OF AGE OR OLDER

25 CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

26 SUBTITLE A. HEALTH COVERAGE IN GENERAL

27 CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE

1 SUBCHAPTER A. GENERAL PROVISIONS

2 Sec. 1201.001. DEFINITIONS

3 Sec. 1201.002. PURPOSE

4 Sec. 1201.003. APPLICABILITY OF CHAPTER

5 Sec. 1201.004. CONSTRUCTION OF CHAPTER

6 Sec. 1201.005. REFERENCES TO CHAPTER

7 Sec. 1201.006. RULEMAKING AUTHORITY

8 Sec. 1201.007. NOTICE AND HEARING

9 Sec. 1201.008. JUDICIAL REVIEW

10 Sec. 1201.009. NONCONFORMING POLICY

11 Sec. 1201.010. THIRD-PARTY OWNERSHIP OF POLICY

12 Sec. 1201.011. COVERAGE FOR PREMIUM PERIOD WITH LIMITATIONS

13 BY AGE OR DATE; MISSTATEMENT OF AGE OF

14 INSURED

15 Sec. 1201.012. DEFENSE OF CLAIM

16 [Sections 1201.013-1201.050 reserved for expansion]

17 SUBCHAPTER B. POLICY TERMS

18 Sec. 1201.051. ENTIRE CONSIDERATION

19 Sec. 1201.052. TIME OF EFFECTIVENESS AND TERMINATION

20 Sec. 1201.053. PERSONS INSURED

21 Sec. 1201.054. APPEARANCE OF TEXT

22 Sec. 1201.055. EXCEPTIONS AND REDUCTIONS OF INDEMNITY

23 Sec. 1201.056. FORM NUMBER

24 Sec. 1201.057. INCORPORATION OF OR REFERENCE TO OTHER

25 DOCUMENTS

26 Sec. 1201.058. NOTIFICATION THAT POLICY IS RETURNABLE; EFFECT

27 OF RETURN

1 Sec. 1201.059. TERMINATION OF COVERAGE BASED ON AGE OF CHILD
2 IN INDIVIDUAL, BLANKET, OR GROUP POLICY

3 Sec. 1201.060. REQUIRED DEFINITION OF "EMERGENCY CARE" IN
4 INDIVIDUAL OR GROUP POLICY

5 Sec. 1201.061. COVERAGE FOR ADOPTED CHILD

6 Sec. 1201.062. COVERAGE FOR CERTAIN CHILDREN IN INDIVIDUAL OR
7 GROUP POLICY OR IN PLAN OR PROGRAM

8 Sec. 1201.063. PROHIBITION OF CERTAIN CRITERIA RELATING TO
9 CHILD'S COVERAGE IN INDIVIDUAL OR GROUP
10 POLICY

11 Sec. 1201.064. COVERAGE FOR CHILD OF SPOUSE IN
12 INDIVIDUAL OR GROUP POLICY

13 Sec. 1201.065. AGE AND SCHOOL ENROLLMENT ELIGIBILITY CRITERIA
14 FOR DEPENDENT CHILDREN IN INDIVIDUAL OR GROUP
15 POLICY; LATE ENROLLMENT

16 [Sections 1201.066-1201.100 reserved for expansion]

17 SUBCHAPTER C. GENERAL POLICY STANDARDS AND PROVISIONS

18 Sec. 1201.101. STANDARDS FOR POLICY PROVISIONS

19 Sec. 1201.102. PROHIBITION OF POLICY PROVISIONS

20 Sec. 1201.103. COMPLIANCE WITH MINIMUM STANDARDS
21 FOR BENEFITS

22 Sec. 1201.104. MINIMUM STANDARDS FOR BENEFITS

23 Sec. 1201.105. MINIMUM STANDARDS FOR BENEFITS FOR LONG-TERM
24 CARE IN INDIVIDUAL, GROUP, OR BLANKET
25 POLICY

26 Sec. 1201.106. IDENTIFICATION OF POLICIES ACCORDING TO
27 COVERAGE PROVIDED

1 Sec. 1201.107. OUTLINE OF COVERAGE REQUIRED

2 Sec. 1201.108. FORMAT AND CONTENT OF OUTLINE OF COVERAGE

3 [Sections 1201.109–1201.150 reserved for expansion]

4 SUBCHAPTER D. PREEXISTING CONDITIONS

5 Sec. 1201.151. COMPLIANCE WITH SUBCHAPTER; PROHIBITION OF
6 DEFENSE

7 Sec. 1201.152. COVERAGE UNDER SIMPLIFIED APPLICATION FORM

8 Sec. 1201.153. COVERAGE FOR INDIVIDUALS AGE 65 OR OLDER

9 Sec. 1201.154. COVERAGE FOR CERTAIN PREVIOUSLY COVERED
10 PERSONS

11 [Sections 1201.155–1201.200 reserved for expansion]

12 SUBCHAPTER E. REQUIRED POLICY PROVISIONS

13 Sec. 1201.201. POLICY PROVISIONS REQUIRED

14 Sec. 1201.202. ORDER OF REQUIRED POLICY PROVISIONS

15 Sec. 1201.203. OTHER POLICY PROVISIONS

16 Sec. 1201.204. POLICY PROVISIONS REQUIRED BY OTHER
17 JURISDICTION

18 Sec. 1201.205. POLICY PROVISIONS FOR POLICY DELIVERED
19 OUTSIDE THIS STATE

20 Sec. 1201.206. FILING PROCEDURE

21 Sec. 1201.207. POLICY PROVISION: ENTIRETY OF CONTRACT;
22 POLICY CHANGES

23 Sec. 1201.208. POLICY PROVISION: INCONTESTABILITY

24 Sec. 1201.209. POLICY PROVISION: GRACE PERIOD

25 Sec. 1201.210. POLICY PROVISION: REINSTATEMENT

26 Sec. 1201.211. POLICY PROVISION: NOTICE OF CLAIM

27 Sec. 1201.212. POLICY PROVISION: CLAIM FORMS

1 Sec. 1201.213. POLICY PROVISION: PROOF OF LOSS
2 Sec. 1201.214. POLICY PROVISION: TIME OF PAYMENT OF
3 CLAIMS
4 Sec. 1201.215. POLICY PROVISION: PAYMENT OF CLAIMS
5 Sec. 1201.216. POLICY PROVISION: PHYSICAL EXAMINATIONS
6 AND AUTOPSY
7 Sec. 1201.217. POLICY PROVISION: LEGAL ACTIONS
8 Sec. 1201.218. POLICY PROVISION: CHANGE OF BENEFICIARY
9 Sec. 1201.219. POLICY PROVISION: CHANGE OF OCCUPATION
10 Sec. 1201.220. POLICY PROVISION: MISSTATEMENT OF AGE
11 Sec. 1201.221. POLICY PROVISION: EXCESS INSURANCE
12 Sec. 1201.222. POLICY PROVISION: RELATION OF EARNINGS
13 TO INSURANCE
14 Sec. 1201.223. POLICY PROVISION: UNPAID PREMIUM
15 Sec. 1201.224. POLICY PROVISION: CANCELLATION
16 Sec. 1201.225. POLICY PROVISION: CONFORMITY WITH STATE
17 STATUTES
18 Sec. 1201.226. POLICY PROVISION: ILLEGAL OCCUPATION
19 Sec. 1201.227. POLICY PROVISION: INTOXICANTS AND
20 NARCOTICS
21 [Sections 1201.228-1201.270 reserved for expansion]
22 SUBCHAPTER F. APPLICATION FOR POLICY
23 Sec. 1201.271. ALTERATION OF POLICY APPLICATION
24 Sec. 1201.272. FALSE STATEMENTS
25 Sec. 1201.273. BINDING STATEMENTS
26 Sec. 1201.274. INSURER'S EVIDENTIARY USE OF APPLICATION FOR
27 REINSTATEMENT OR RENEWAL

[Sections 1201.275-1201.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT

Sec. 1201.701. CIVIL PENALTY

Sec. 1201.702. ACTION AGAINST CERTIFICATE OF AUTHORITY

OR LICENSE

CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1201.001. DEFINITIONS. In this chapter:

(1) "Accident and health insurance policy" includes any policy or contract that provides insurance against loss resulting from:

(A) accidental bodily injury;

(B) accidental death; or

(C) sickness.

(2) "Policy" means the entire contract between an insurer and an insured and includes riders, endorsements, and the application, if attached. (V.T.I.C. Art. 3.70-1, Secs. (B)(3), (4).)

Sec. 1201.002. PURPOSE. The purpose of this chapter is to:

(1) provide for reasonable standardization, readability, and simplification of terms and coverages in individual accident and health insurance policies;

(2) promote public understanding of coverages;

(3) eliminate provisions in individual accident and health insurance policies that may be unjust, unfair, misleading, or unreasonably confusing in connection with:

(A) the purchase of coverage; or

(B) the settlement of claims; and

(4) provide for full and fair disclosure in sales of accident and health coverage. (V.T.I.C. Art. 3.70-1, Sec. (A).)

Sec. 1201.003. APPLICABILITY OF CHAPTER. (a) This chapter applies only to an accident and health insurance policy delivered or issued for delivery in this state.

(b) Except as otherwise provided by this chapter, this chapter applies only to an individual accident and health insurance policy delivered or issued for delivery by:

(1) a life, health, and accident insurance company;

(2) a mutual insurance company, including:

(A) a mutual life insurance company; and

(B) a mutual assessment life insurance company;

(3) a local mutual aid association;

(4) a mutual or natural premium life or casualty insurance company;

(5) a general casualty company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842; or

(9) another insurer required by law to be authorized by the department.

(c) This chapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884.

(d) This chapter does not apply to:

(1) any society, company, or other insurer whose activities are exempt by statute from the control of the department and that is entitled by statute to a certificate from the department that shows the entity's exempt status;

(2) a credit accident and health insurance policy issued under Chapter 1153;

(3) a workers' compensation insurance policy;

(4) a liability insurance policy, with or without supplementary expense coverage;

(5) a reinsurance policy or contract;

(6) a blanket or group insurance policy, except as otherwise provided by this chapter; or

(7) a life insurance endowment or annuity contract or a contract supplemental to a life insurance endowment or annuity contract if the contract or supplemental contract contains only provisions relating to accident and health insurance that:

(A) provide additional benefits in case of accidental death, accidental dismemberment, or accidental loss of sight; or

(B) operate to:

(i) safeguard the contract or supplemental contract against lapse; or

(ii) give a special surrender value, a special benefit, or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

1 (e) Subchapters C and D do not apply to a conversion policy
2 issued under a contractual conversion privilege under a group
3 accident and health insurance policy. (V.T.I.C. Art. 3.70-1, Sec.
4 (C) (part); Art. 3.70-8, Secs. (a) (part), (b).)

5 Sec. 1201.004. CONSTRUCTION OF CHAPTER. This chapter does
6 not enlarge the powers of an entity listed in Section 1201.003.
7 (V.T.I.C. Art. 3.70-1, Sec. (C) (part).)

8 Sec. 1201.005. REFERENCES TO CHAPTER. In this chapter, a
9 reference to this chapter includes a reference to:

10 (1) Section 1202.052;

11 (2) Section 1271.005(a), to the extent that the
12 subsection relates to the applicability of Section 1201.105, and
13 Sections 1271.005(d) and (e);

14 (3) Chapter 1351;

15 (4) Subchapters C and E, Chapter 1355;

16 (5) Chapter 1356;

17 (6) Chapter 1365;

18 (7) Subchapter A, Chapter 1367; and

19 (8) Subchapters A, B, and G, Chapter 1451. (New.)

20 Sec. 1201.006. RULEMAKING AUTHORITY. The commissioner may
21 adopt reasonable rules as necessary to implement the purposes and
22 provisions of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (D).)

23 Sec. 1201.007. NOTICE AND HEARING. The commissioner may
24 adopt a general rule or order relating to a matter covered by this
25 chapter only after a hearing held after the 10th day following the
26 date the department by mail notifies each insurer to which this
27 chapter applies. (V.T.I.C. Art. 3.70-10 (part).)

1 Sec. 1201.008. JUDICIAL REVIEW. An insurer that is
2 dissatisfied with an order, act, rule, administrative ruling, or
3 decision of the commissioner under this chapter may, after failing
4 to get relief from the commissioner, file a petition seeking
5 judicial review of the order, act, rule, ruling, or decision in
6 accordance with Subchapter D, Chapter 36. The action has
7 precedence over all other causes on the docket of a different
8 nature. (V.T.I.C. Art. 3.70-10 (part).)

9 Sec. 1201.009. NONCONFORMING POLICY. (a) This chapter
10 governs the rights, duties, and obligations of the insurer, the
11 insured, and the beneficiary of an accident and health insurance
12 policy regardless of a provision in the policy that conflicts with
13 this chapter.

14 (b) An accident and health insurance policy that violates
15 this chapter is a valid policy, but the policy shall be construed in
16 a manner to make the policy consistent with this chapter. (V.T.I.C.
17 Art. 3.70-4, Sec. (B).)

18 Sec. 1201.010. THIRD-PARTY OWNERSHIP OF POLICY. The use of
19 "insured" in this chapter does not prevent a person with an
20 insurable interest, other than the insured, from:

21 (1) applying for and owning an individual accident and
22 health insurance policy covering the insured; or

23 (2) being entitled to an indemnity, right, or benefit
24 provided for in an individual accident and health insurance policy
25 covering the insured. (V.T.I.C. Art. 3.70-3, Sec. (E).)

26 Sec. 1201.011. COVERAGE FOR PREMIUM PERIOD WITH LIMITATIONS
27 BY AGE OR DATE; MISSTATEMENT OF AGE OF INSURED. (a) Regardless of a

1 provision in an individual accident and health insurance policy
2 that specifies a date, by age limitation or otherwise, after which
3 coverage under the policy is not effective, coverage continues in
4 force, subject to any right of cancellation, until the end of the
5 period for which the insurer accepts a premium if:

6 (1) the insurer accepts the premium after the
7 specified date; or

8 (2) the specified date falls before the end of the
9 period for which the insurer accepts the premium.

10 (b) Notwithstanding Subsection (a), if the age of the
11 insured is misstated and, because of the insured's correct age,
12 coverage of the insured would not have become effective or would
13 have terminated before the insurer's acceptance of a premium, the
14 liability of the insurer is limited to the refund, on request, of
15 the premiums paid for the period not covered by the policy.
16 (V.T.I.C. Art. 3.70-7.)

17 Sec. 1201.012. DEFENSE OF CLAIM. The following actions by
18 an insurer do not operate as a waiver of the insurer's rights in
19 defense of a claim that arises under an individual accident and
20 health insurance policy:

21 (1) acknowledgment of the receipt of notice given
22 under the policy;

23 (2) provision of a form for filing a proof of loss;

24 (3) acceptance of a proof of loss; or

25 (4) investigation of a claim under the policy.

26 (V.T.I.C. Art. 3.70-6.)

27 [Sections 1201.013-1201.050 reserved for expansion]

SUBCHAPTER B. POLICY TERMS

Sec. 1201.051. ENTIRE CONSIDERATION. An individual accident and health insurance policy must state the entire monetary and other consideration for the policy in the policy or in the application, if the application is made a part of the policy. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.052. TIME OF EFFECTIVENESS AND TERMINATION. An individual accident and health insurance policy must state the time the insurance takes effect and the time the insurance terminates. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.053. PERSONS INSURED. (a) Except as provided by this section, an individual accident and health insurance policy may not insure more than one individual.

(b) On the application of an adult member of a family, an individual accident and health insurance policy may, at the time of original issuance or by subsequent amendment, insure two or more eligible members of the adult's family, including a spouse, unmarried children younger than 25 years of age, including a grandchild of the adult as described by Section 1201.062(a)(1), a child the adult is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state, and any other individual dependent on the adult.

(c) The adult who applies for the individual accident and health insurance policy is considered the policyholder. (V.T.I.C. Art. 3.70-2, Sec. (A) (part), as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Sec. 1201.054. APPEARANCE OF TEXT. (a) In this section,

"text" includes all printed matter of an individual accident and health insurance policy except:

- (1) the name and address of the insurer;
- (2) the name or title of the policy;
- (3) the brief description, if any; and
- (4) captions and subcaptions.

(b) An individual accident and health insurance policy must have:

(1) a style, arrangement, or overall appearance that does not give undue prominence to any portion of the text; and

(2) every printed portion of its text and of any endorsements or attached papers printed plainly in a lightfaced type:

(A) of a style in general use; and

(B) in a uniform size not less than 10-point with a lowercase unspaced alphabet length not less than 120-point.

(c) Subsection (b)(2) does not apply to a copy of an application or identification card. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Sec. 1201.055. EXCEPTIONS AND REDUCTIONS OF INDEMNITY. (a) An individual accident and health insurance policy must state each exception to or reduction of indemnity for the policy.

(b) Except as provided by Subchapter E, each exception to or reduction of indemnity for the policy must be printed, at the insurer's option:

(1) with the benefit provision to which the exception or reduction applies; or

1 (2) under an appropriate caption such as:

2 (A) "Exceptions"; or

3 (B) "Exceptions and Reductions."

4 (c) Notwithstanding Subsection (b), if an exception or
5 reduction specifically applies only to a particular benefit of an
6 individual accident and health insurance policy, the statement of
7 the exception or reduction must be included with the benefit
8 provision to which the exception or reduction applies. (V.T.I.C.
9 Art. 3.70-2, Sec. (A) (part).)

10 Sec. 1201.056. FORM NUMBER. Each form that constitutes a
11 part of an individual accident and health insurance policy,
12 including each rider or endorsement, must be identified by a form
13 number placed in the lower left corner of the first page of the
14 form. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

15 Sec. 1201.057. INCORPORATION OF OR REFERENCE TO OTHER
16 DOCUMENTS. (a) An individual accident and health insurance policy
17 that provides that a portion of the charter, rules, constitution,
18 or bylaws of the insurer are a part of the policy must state that
19 portion fully in the policy.

20 (b) An individual accident and health insurance policy may
21 incorporate or refer to:

22 (1) a statement of rates or classification of risks;

23 or

24 (2) a short-rate table filed with the department.

25 (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

26 Sec. 1201.058. NOTIFICATION THAT POLICY IS RETURNABLE;
27 EFFECT OF RETURN. (a) An individual accident and health insurance

1 policy must include a notice that states in substance that the
2 individual to whom the policy is issued is entitled to have the
3 premium paid refunded if, after the individual examines the policy,
4 the individual is not satisfied with the policy for any reason and
5 returns the policy not later than the 10th day after the date the
6 policy is delivered to the individual.

7 (b) An individual accident and health insurance policy
8 returned to the insurer at the insurer's home or branch office or to
9 the agent through whom the policy was purchased within the time
10 provided by the notice is void from the date the policy was issued,
11 and the parties are in the same position as if the policy had not
12 been issued.

13 (c) The notice required by this section may be printed on
14 the policy or attached to the policy.

15 (d) This section does not apply to a single premium
16 nonrenewable policy. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

17 Sec. 1201.059. TERMINATION OF COVERAGE BASED ON AGE OF
18 CHILD IN INDIVIDUAL, BLANKET, OR GROUP POLICY. (a) An accident and
19 health insurance policy, including an individual, blanket, or group
20 policy, and including a policy issued by a corporation operating
21 under Chapter 842, that provides that coverage of a child
22 terminates when the child attains a limiting age specified in the
23 policy must provide in substance that the child's attainment of
24 that age does not terminate coverage while the child is:

25 (1) incapable of self-sustaining employment because
26 of mental retardation or physical disability; and

27 (2) chiefly dependent on the insured or group member

1 for support and maintenance.

2 (b) To obtain coverage for a child as described by
3 Subsection (a), the insured or group member must provide to the
4 insurer proof of the child's incapacity and dependency:

5 (1) not later than the 31st day after the date the
6 child attains the limiting age; and

7 (2) subsequently as the insurer requires, except that
8 the insurer may not require proof more frequently than annually
9 after the second anniversary of the date the child attains the
10 limiting age. (V.T.I.C. Art. 3.70-2, Sec. (C); Art. 3.70-8, Sec.
11 (a) (part).)

12 Sec. 1201.060. REQUIRED DEFINITION OF "EMERGENCY CARE" IN
13 INDIVIDUAL OR GROUP POLICY. An individual or group accident and
14 health insurance policy that provides an emergency care benefit,
15 including a policy issued by a corporation operating under Chapter
16 842, must define "emergency care" as follows:

17 "Emergency care" means bona fide emergency services provided
18 after the sudden onset of a medical condition manifesting itself by
19 acute symptoms of sufficient severity, including severe pain, such
20 that the absence of immediate medical attention could reasonably be
21 expected to result in:

22 (1) placing the patient's health in serious jeopardy;

23 (2) serious impairment to bodily functions; or

24 (3) serious dysfunction of any bodily organ or part.

25 (V.T.I.C. Art. 3.70-2, Sec. (I).)

26 Sec. 1201.061. COVERAGE FOR ADOPTED CHILD. (a) An
27 individual accident and health insurance policy that provides

1 coverage for an insured's immediate family or children may not,
2 solely because the insured's child is adopted:

3 (1) exclude the child from coverage; or

4 (2) limit coverage for the child.

5 (b) For the purposes of this section, a child is an
6 insured's child if the insured is a party to a suit in which the
7 insured seeks to adopt the child. (V.T.I.C. Art. 3.70-2, Sec. (K).)

8 Sec. 1201.062. COVERAGE FOR CERTAIN CHILDREN IN INDIVIDUAL
9 OR GROUP POLICY OR IN PLAN OR PROGRAM. (a) An individual or group
10 accident and health insurance policy that is delivered, issued for
11 delivery, or renewed in this state, including a policy issued by a
12 corporation operating under Chapter 842, or a self-funded or
13 self-insured welfare or benefit plan or program, to the extent that
14 regulation of the plan or program is not preempted by federal law,
15 that provides coverage for a child of an insured or group member, on
16 payment of a premium, must provide coverage for:

17 (1) each grandchild of the insured or group member if
18 the grandchild is:

19 (A) unmarried;

20 (B) younger than 25 years of age; and

21 (C) a dependent of the insured or group member
22 for federal income tax purposes at the time application for
23 coverage of the grandchild is made; and

24 (2) each child for whom the insured or group member
25 must provide medical support under an order issued under Chapter
26 154, Family Code, or enforceable by a court in this state.

27 (b) Coverage for a grandchild of the insured or group member

1 may not be terminated solely because the grandchild is no longer a
2 dependent of the insured or group member for federal income tax
3 purposes. (V.T.I.C. Art. 3.70-2, Sec. (L) (part), as amended Acts
4 77th Leg., R.S., Chs. 396 and 1027.)

5 Sec. 1201.063. PROHIBITION OF CERTAIN CRITERIA RELATING TO
6 CHILD'S COVERAGE IN INDIVIDUAL OR GROUP POLICY. Regarding a
7 natural or adopted child of an insured or group member or a child
8 for whom the insured or group member must provide medical support
9 under an order issued under Chapter 154, Family Code, or
10 enforceable by a court in this state, an individual or group
11 accident and health insurance policy that provides coverage for a
12 child of an insured or group member may not set a different premium
13 for the child, exclude the child from coverage, or discontinue
14 coverage of the child because:

15 (1) the child does not reside with the insured or group
16 member; or

17 (2) the insured or group member does not claim the
18 child as an exemption for federal income tax purposes under Section
19 151(c)(1)(B), Internal Revenue Code of 1986. (V.T.I.C. Art.
20 3.70-2, Sec. (M)(1).)

21 Sec. 1201.064. COVERAGE FOR CHILD OF SPOUSE IN INDIVIDUAL
22 OR GROUP POLICY. An individual or group accident and health
23 insurance policy that provides coverage for a child of an insured or
24 group member may not:

25 (1) set a premium for a child that is different from
26 the premium for other children because the child is the natural or
27 adopted child of the spouse of the insured or group member;

1 (2) exclude a child described by Subdivision (1) from
2 coverage; or

3 (3) discontinue coverage of a child described by
4 Subdivision (1). (V.T.I.C. Art. 3.70-2, Sec. (M)(2).)

5 Sec. 1201.065. AGE AND SCHOOL ENROLLMENT ELIGIBILITY
6 CRITERIA FOR DEPENDENT CHILDREN IN INDIVIDUAL OR GROUP POLICY; LATE
7 ENROLLMENT. (a) An individual or group accident and health
8 insurance policy may contain criteria relating to a maximum age or
9 enrollment in school to establish continued eligibility for
10 coverage of a child younger than 25 years of age.

11 (b) In the case of a late enrollment, an insurer may require
12 evidence of insurability that is satisfactory to the insurer before
13 a child is included for coverage under the policy. (V.T.I.C. Art.
14 3.70-2, Sec. (M)(3).)

15 [Sections 1201.066-1201.100 reserved for expansion]

16 SUBCHAPTER C. GENERAL POLICY STANDARDS AND PROVISIONS

17 Sec. 1201.101. STANDARDS FOR POLICY PROVISIONS. (a) The
18 commissioner shall adopt reasonable rules establishing specific
19 standards for:

20 (1) the content of an individual accident and health
21 insurance policy; and

22 (2) the manner of sale of an individual accident and
23 health insurance policy, including disclosures required to be made
24 in connection with the sale.

25 (b) Rules adopted under this section must establish
26 standards for:

27 (1) policy readability; and

1 (2) full and fair policy disclosures.

2 (c) Standards established under this section may include
3 standards that address:

4 (1) terms of policy renewability;

5 (2) initial and subsequent conditions of eligibility;

6 (3) nonduplication of coverage;

7 (4) coverage of dependents;

8 (5) preexisting conditions;

9 (6) termination of insurance;

10 (7) probationary periods;

11 (8) limitations;

12 (9) exceptions;

13 (10) reductions;

14 (11) elimination periods;

15 (12) requirements for replacement;

16 (13) recurrent conditions; and

17 (14) definitions of terms, including definitions of:

18 (A) "accident";

19 (B) "accidental means";

20 (C) "guaranteed renewable and noncancellable";

21 (D) "hospital";

22 (E) "injury";

23 (F) "nervous disorder";

24 (G) "partial disability";

25 (H) "physician";

26 (I) "sickness"; and

27 (J) "total disability."

1 (d) A definition of "hospital" adopted under Subsection (c)
2 may not apply to a corporation operating under Chapter 842.
3 (V.T.I.C. Art. 3.70-1, Sec. (E)(1).)

4 Sec. 1201.102. PROHIBITION OF POLICY PROVISIONS. The
5 commissioner may adopt rules prohibiting specific individual
6 accident and health insurance policy provisions not specifically
7 authorized by statute that the commissioner determines are unjust,
8 unfair, or unfairly discriminatory to:

- 9 (1) the policyholder;
10 (2) an insured under the policy; or
11 (3) a beneficiary. (V.T.I.C. Art. 3.70-1, Sec.
12 (E)(2).)

13 Sec. 1201.103. COMPLIANCE WITH MINIMUM STANDARDS FOR
14 BENEFITS. (a) An individual accident and health insurance policy
15 must meet the minimum standards for benefits established under
16 Section 1201.104 for each category of coverage provided under the
17 policy.

18 (b) Subsection (a) does not apply if the commissioner
19 determines that the policy is a supplemental policy or experimental
20 policy or determines that the policy will fulfill a reasonable
21 public need and the policy meets the requirements of Chapter 1701.
22 (V.T.I.C. Art. 3.70-1, Sec. (F)(3).)

23 Sec. 1201.104. MINIMUM STANDARDS FOR BENEFITS. (a) For
24 individual accident and health insurance policies, the
25 commissioner shall adopt rules establishing minimum standards for
26 benefits under each of the following categories of coverage:

- 27 (1) basic hospital expense;

- (2) basic medical-surgical expense;
- (3) hospital confinement indemnity;
- (4) major medical expense;
- (5) disability income protection;
- (6) accident only;
- (7) specified disease;
- (8) specified accident; and
- (9) limited benefit.

(b) This section does not prohibit the issuance of an individual accident and health insurance policy that combines categories of coverage listed by this section. (V.T.I.C. Art. 3.70-1, Secs. (F)(1), (2).)

Sec. 1201.105. MINIMUM STANDARDS FOR BENEFITS FOR LONG-TERM CARE IN INDIVIDUAL, GROUP, OR BLANKET POLICY. (a) The commissioner shall adopt rules establishing minimum standards for benefits for long-term care coverage under individual, group, and blanket accident and health insurance policies and certificates delivered or issued for delivery in this state.

(b) Rules adopted under this section apply to group coverages delivered or issued for delivery by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-1, Sec. (F)(5) (part); Art. 3.70-8, Sec. (a) (part).)

Sec. 1201.106. IDENTIFICATION OF POLICIES ACCORDING TO COVERAGE PROVIDED. The commissioner shall prescribe the method to identify an individual accident and health insurance policy according to the coverages the policy provides. (V.T.I.C. Art. 3.70-1, Sec. (F)(4).)

1 Sec. 1201.107. OUTLINE OF COVERAGE REQUIRED. (a) An
2 outline of coverage for an individual accident and health insurance
3 policy must be delivered to the applicant at the time application is
4 made, and an acknowledgment of receipt or certificate of delivery
5 of an outline of coverage must be provided to the insurer with the
6 application.

7 (b) If the policy issued differs from the policy for which
8 the applicant applied, an outline of coverage that properly
9 describes the policy must:

- 10 (1) accompany the policy when delivered; and
11 (2) clearly state that the policy is not the policy for
12 which the applicant applied.

13 (c) Subsection (a) does not apply to a direct response
14 insurance product.

15 (d) An outline of coverage under a direct response insurance
16 product must accompany the policy. (V.T.I.C. Art. 3.70-1, Sec.
17 (G)(1).)

18 Sec. 1201.108. FORMAT AND CONTENT OF OUTLINE OF COVERAGE.
19 (a) In this section, "format" means style, arrangement, and
20 overall appearance, including:

- 21 (1) the size, color, and prominence of type; and
22 (2) the arrangement of text and captions.

23 (b) The commissioner shall prescribe the format and content
24 of an outline of coverage required by Section 1201.107.

25 (c) An outline of coverage must include:
26 (1) a statement that identifies the applicable
27 categories of coverage listed by Section 1201.104 and provided by

1 the policy;

2 (2) a description of the principal benefits and
3 coverage provided by the policy;

4 (3) a statement of the exceptions, reductions, and
5 limitations in the policy;

6 (4) a statement of the renewal provision, including
7 any reservation of the insurer's right to change premiums;

8 (5) a statement that:

9 (A) the outline is a summary of the policy issued
10 or applied for; and

11 (B) the policy should be consulted to determine
12 governing contractual provisions;

13 (6) as the commissioner determines necessary to carry
14 out the purposes of this chapter, a summary of the provisions
15 required by Subchapter E to be in the policy; and

16 (7) any other statement, description, or outline that
17 the commissioner determines is reasonably necessary to carry out
18 the purposes of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (G)(2).)

19 [Sections 1201.109-1201.150 reserved for expansion]

20 SUBCHAPTER D. PREEXISTING CONDITIONS

21 Sec. 1201.151. COMPLIANCE WITH SUBCHAPTER; PROHIBITION OF
22 DEFENSE. Except as provided by this subchapter, an individual
23 accident and health insurance policy may not include a provision
24 that permits a defense based on a preexisting condition. (V.T.I.C.
25 Art. 3.70-1, Sec. (H)(3).)

26 Sec. 1201.152. COVERAGE UNDER SIMPLIFIED APPLICATION FORM.

27 (a) Notwithstanding Clause (b) of the provision required by

1 Section 1201.208(a), an individual accident and health insurance
2 policy must cover any loss that occurs after 12 months from a
3 preexisting condition if the insurer uses a simplified application
4 form that does not include a question concerning the applicant's
5 health history or medical treatment history.

6 (b) This section applies regardless of whether the
7 simplified application form includes a question regarding the
8 applicant's health at the time of application.

9 (c) This section does not require an insurer to cover a loss
10 from a condition that the policy specifically excludes from
11 coverage. (V.T.I.C. Art. 3.70-1, Sec. (H)(1).)

12 Sec. 1201.153. COVERAGE FOR INDIVIDUALS AGE 65 OR OLDER.

13 (a) Notwithstanding Section 1201.152 or Clause (b) of the
14 provision required by Section 1201.208(a), an individual accident
15 and health insurance policy delivered or issued for delivery to an
16 individual who is 65 years of age or older may not include a
17 provision that excludes from coverage a loss that occurs from a
18 preexisting condition more than six months after the effective date
19 of coverage under the policy.

20 (b) Notwithstanding Subsection (a), the commissioner may
21 authorize a policy provision that excludes coverage for a
22 preexisting condition for a period of not more than one year if the
23 commissioner determines that the provision would serve the public
24 interest.

25 (c) This section does not require an insurer to provide
26 coverage for a loss from a preexisting condition specifically
27 excluded from coverage by name or specific description in an

1 exclusion endorsement or rider that is effective on the date of the
2 loss. (V.T.I.C. Art. 3.70-1, Sec. (H)(2).)

3 Sec. 1201.154. COVERAGE FOR CERTAIN PREVIOUSLY COVERED
4 PERSONS. (a) In this section, "creditable coverage" has the
5 meaning assigned by Section 1205.004.

6 (b) A preexisting condition provision in an individual
7 accident and health insurance policy may not apply to an
8 individual:

9 (1) who was continuously covered for an aggregate
10 period of 18 months by creditable coverage that was in effect up to
11 a date not more than 63 days before the effective date of the
12 individual coverage, excluding any waiting period; and

13 (2) whose most recent creditable coverage was under:

14 (A) a group health plan;

15 (B) a governmental plan; or

16 (C) a church plan.

17 (c) In determining whether a preexisting condition
18 provision of an individual accident and health insurance policy
19 applies to an individual, an insurer shall credit the time the
20 individual previously was covered under creditable coverage if the
21 previous coverage was in effect at any time during the 18 months
22 preceding the effective date of the individual coverage. (V.T.I.C.
23 Art. 3.70-1, Sec. (H)(4).)

24 [Sections 1201.155-1201.200 reserved for expansion]

25 SUBCHAPTER E. REQUIRED POLICY PROVISIONS

26 Sec. 1201.201. POLICY PROVISIONS REQUIRED. (a) Except as
27 provided by Subsections (b) and (c), an individual accident and

1 health insurance policy must contain the provisions required by
2 this subchapter in the words provided by this subchapter.

3 (b) An insurer may substitute for a policy provision
4 required by this subchapter a provision with different wording
5 approved by the commissioner in accordance with reasonable rules
6 adopted by the commissioner. A substituted provision may not be
7 less favorable to an insured or a beneficiary of the policy than
8 the provision required by this subchapter.

9 (c) If a policy provision required by this subchapter is
10 wholly or partly inapplicable to or inconsistent with the coverage
11 provided by a particular form of policy, the insurer, with the
12 commissioner's approval, shall:

13 (1) omit from the policy each inapplicable provision
14 or part of a provision; and

15 (2) modify each inconsistent provision or part of a
16 provision so that the provision as contained in the policy is
17 consistent with the coverage provided by the policy.

18 (d) A policy provision required by this subchapter must be
19 preceded by the caption for the provision provided by this
20 subchapter or, at the option of the insurer, by an appropriate
21 individual or group caption or subcaption approved by the
22 commissioner. (V.T.I.C. Art. 3.70-3, Secs. (A) (part), (B) (part),
23 (C).)

24 Sec. 1201.202. ORDER OF REQUIRED POLICY PROVISIONS. (a)
25 Except as provided by Subsection (b), policy provisions required by
26 this subchapter or corresponding substitute provisions must be
27 printed in the same consecutive order as provided by this

1 subchapter.

2 (b) An insurer may print a policy provision required by this
3 subchapter or a corresponding substitute provision as a unit in any
4 part of the policy with other provisions to which the provision is
5 logically related.

6 (c) A policy printed under Subsection (b) may not be wholly
7 or partly unintelligible, uncertain, ambiguous, abstruse, or
8 likely to mislead a person to whom the policy is offered, delivered,
9 or issued. (V.T.I.C. Art. 3.70-3, Sec. (D).)

10 Sec. 1201.203. OTHER POLICY PROVISIONS. A policy provision
11 that is not otherwise subject to this subchapter may not make an
12 individual accident and health insurance policy or any portion of
13 the policy less favorable in any way to the insured or the
14 beneficiary than the policy provisions that are subject to this
15 chapter. (V.T.I.C. Art. 3.70-4, Sec. (A).)

16 Sec. 1201.204. POLICY PROVISIONS REQUIRED BY OTHER
17 JURISDICTION. An individual accident and health insurance policy
18 of a foreign or alien insurer may contain any provision that is:

19 (1) not less favorable to the insured or the
20 beneficiary than the provisions of this chapter; and

21 (2) prescribed or required by the law of the state
22 under which the insurer is organized. (V.T.I.C. Art. 3.70-3, Sec.
23 (F)(1).)

24 Sec. 1201.205. POLICY PROVISIONS FOR POLICY DELIVERED
25 OUTSIDE THIS STATE. An individual accident and health insurance
26 policy issued by a domestic insurer for delivery in another state or
27 country may contain any provision permitted or required by the laws

1 of that state or country. (V.T.I.C. Art. 3.70-3, Sec. (F)(2).)

2 Sec. 1201.206. FILING PROCEDURE. (a) The commissioner may
3 adopt reasonable rules regarding the procedure for submitting
4 policies subject to this chapter that are necessary, proper, or
5 advisable for the administration of this chapter.

6 (b) This section does not limit any authority otherwise
7 granted by law to the commissioner or department. (V.T.I.C. Art.
8 3.70-3, Sec. (G).)

9 Sec. 1201.207. POLICY PROVISION: ENTIRETY OF CONTRACT;
10 POLICY CHANGES. An individual accident and health insurance policy
11 must contain the following provision:

12 "Entire Contract; Changes: This policy, including the
13 endorsements and the attached papers, if any, constitutes the
14 entire contract of insurance. A change in this policy is not valid
15 until the change is approved by an executive officer of the insurer
16 and unless the approval is endorsed on or attached to the policy.
17 An agent does not have authority to change this policy or to waive
18 any of its provisions." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

19 Sec. 1201.208. POLICY PROVISION: INCONTESTABILITY. (a)
20 Except as provided by Subsection (c), an individual accident and
21 health insurance policy must contain the following provision:

22 "Time Limit on Certain Defenses: (a) After the second
23 anniversary of the date this policy is issued, a misstatement,
24 other than a fraudulent misstatement, made by the applicant in the
25 application for the policy may not be used to void the policy or to
26 deny a claim for loss incurred or disability (as defined in the
27 policy) beginning after that anniversary.

1 "(b) A claim for loss incurred or disability (as defined in
2 the policy) beginning after the second anniversary of the date this
3 policy is issued may not be reduced or denied on the ground that a
4 disease or physical condition not excluded from coverage by name or
5 specific description effective on the date of loss existed before
6 the effective date of coverage of this policy."

7 (b) Clause (a) of the provision required by Subsection (a)
8 does not:

9 (1) affect any legal requirement for avoidance of a
10 policy or denial of a claim during the initial two-year period; or

11 (2) limit the application of Section 1201.219,
12 1201.220, or 1201.221 in a case of a misstatement regarding age,
13 occupation, or other insurance.

14 (c) For a policy that provides that the insured is entitled
15 to continue the policy in force by the timely payment of premiums
16 until the insured reaches at least 50 years of age or, if the policy
17 was issued after the insured reached 44 years of age, until at least
18 the fifth anniversary of the policy's date of issuance, an insurer
19 may use the following clause instead of Clause (a) of the provision
20 required by Subsection (a):

21 "After this policy has been in force for a period of two years
22 during the lifetime of the insured (excluding any period during
23 which the insured is disabled), it shall become incontestible as to
24 the statements contained in the application."

25 (d) The provision provided by Subsection (c) must be under
26 the caption "Incontestable." An insurer that uses the provision
27 may omit the parenthetical clause. (V.T.I.C. Art. 3.70-3, Sec. (A)

(part).)

Sec. 1201.209. POLICY PROVISION: GRACE PERIOD. (a) An individual accident and health insurance policy must contain the following provision:

"Grace Period: A grace period of ____ (insert appropriate number) days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force."

(b) The number of days of the grace period may not be less than:

- (1) 7 for a weekly premium policy;
- (2) 10 for a monthly premium policy; or
- (3) 31 for any other policy.

(c) A policy that contains a cancellation provision may add, at the end of the provision required by Subsection (a): "subject to the right of the insurer to cancel the policy in accordance with the policy's cancellation provision."

(d) A policy in which the insurer reserves the right to refuse any renewal must include the following provision at the beginning of the provision required by Subsection (a):

"Unless, not less than five days before the premium due date, the insurer has delivered to the insured, or has mailed to the insured's last address as shown by the insurer's records, a written notice of the insurer's intention not to renew this policy beyond the period for which the premium has been accepted,"
(V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Sec. 1201.210. POLICY PROVISION: REINSTATEMENT. (a)

1 Except as provided by Subsection (b), an individual accident and
2 health insurance policy must contain the following provision:

3 "Reinstatement: If a renewal premium is not paid before the
4 expiration of the period granted for the insured to make the
5 payment, a subsequent acceptance of the premium by the insurer or
6 any agent authorized by the insurer to accept the premium, without
7 requiring in connection with the acceptance an application for
8 reinstatement, reinstates the policy. However, if the insurer or
9 authorized agent requires an application for reinstatement and
10 issues a conditional receipt for the premium tendered, the policy
11 will be reinstated on approval of the application by the insurer or,
12 if the application is not approved, on the 45th day after the date
13 of the conditional receipt unless the insurer before that date has
14 notified the insured in writing of the insurer's disapproval of the
15 application. The reinstated policy covers only loss resulting from
16 an accidental injury sustained after the date of reinstatement and
17 loss due to sickness that begins more than 10 days after the date of
18 reinstatement. In all other respects the insured and insurer have
19 the same rights under the reinstated policy as they had under the
20 policy immediately before the due date of the defaulted premium,
21 subject to any provisions endorsed in the policy or attached to the
22 policy in connection with the reinstatement. Any premium accepted
23 in connection with a reinstatement shall be applied to a period for
24 which premium has not been previously paid, but not to any period
25 more than 60 days before the date of reinstatement."

26 (b) The insurer may omit the last sentence of the provision
27 required by Subsection (a) in a policy that provides that the

1 insured is entitled to continue the policy in force by the timely
2 payment of premiums until the insured reaches at least 50 years of
3 age or, if the policy was issued after the insured reached 44 years
4 of age, until at least the fifth anniversary of the policy's date of
5 issuance. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

6 Sec. 1201.211. POLICY PROVISION: NOTICE OF CLAIM. (a)
7 Except as provided by Subsection (b), an individual accident and
8 health insurance policy must contain the following provision:

9 "Notice of Claim: A written notice of claim must be given to
10 the insurer before the 21st day after the date of the occurrence or
11 beginning of any loss covered by the policy, or as soon after that
12 date as is reasonably possible. A notice given by or on behalf of
13 the insured or the beneficiary to the insurer at _____ (insert the
14 location of any office the insurer designates for the purpose), or
15 to any authorized agent of the insurer, with information sufficient
16 to identify the insured, constitutes notice to the insurer."

17 (b) In a policy that provides a loss of time benefit that may
18 be payable for at least two years, an insurer may insert, between
19 the first and second sentences of the provision required by
20 Subsection (a), the following provision:

21 "Subject to the qualifications below, and except in the event
22 of a legal incapacity, if the insured suffers loss of time on
23 account of disability for which indemnity may be payable for at
24 least two years, the insured shall, at least once in every _____
25 (insert appropriate number) months after having given notice of
26 claim, give to the insurer notice of continuance of the disability.
27 In applying this provision, the period of _____ (insert

1 appropriate number) months following a filing of proof by the
2 insured or any payment by the insurer on account of the claim or any
3 denial of liability in whole or in part by the insurer shall be
4 excluded. Delay in giving the notice does not impair the insured's
5 right to any indemnity that would otherwise have accrued during the
6 period of _____ (insert appropriate number) months preceding the
7 date on which the notice is actually given."

8 (c) The number of months inserted in the clause permitted by
9 Subsection (b) may not be less than one or greater than six.
10 (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

11 Sec. 1201.212. POLICY PROVISION: CLAIM FORMS. (a) Except
12 as provided by Subsection (b), an individual accident and health
13 insurance policy must contain the following provision:

14 "Claim Forms: The insurer, on receipt of a notice of claim,
15 will provide to the claimant the forms usually provided by the
16 insurer for filing proof of loss. If the forms are not provided
17 before the 16th day after the date of the notice, the claimant shall
18 be considered to have complied with the requirements of this policy
19 as to proof of loss on submitting, within the time fixed in the
20 policy for filing proofs of loss, written proof covering the
21 occurrence, the character, and the extent of the loss for which the
22 claim is made."

23 (b) The provision required by this section is not required
24 to be contained in a policy issued by a corporation operating under
25 Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

26 Sec. 1201.213. POLICY PROVISION: PROOF OF LOSS. An
27 individual accident and health insurance policy must contain the

1 following provision:

2 "Proof of Loss: For a claim for loss for which this policy
3 provides any periodic payment contingent on continuing loss, a
4 written proof of loss must be provided to the insurer at the
5 insurer's designated office before the 91st day after the
6 termination of the period for which the insurer is liable. For a
7 claim for any other loss, a written proof of loss must be provided
8 to the insurer at the insurer's designated office before the 91st
9 day after the date of the loss. Failure to provide the proof within
10 the required time does not invalidate or reduce any claim if it was
11 not reasonably possible to give proof within the required time. In
12 that case, the proof must be provided as soon as reasonably possible
13 but not later than one year after the time proof is otherwise
14 required, except in the event of a legal incapacity." (V.T.I.C.
15 Art. 3.70-3, Sec. (A) (part).)

16 Sec. 1201.214. POLICY PROVISION: TIME OF PAYMENT OF
17 CLAIMS. (a) Except as provided by Subsection (c), an individual
18 accident and health insurance policy must contain the following
19 provision:

20 "Time of Payment of Claims: Indemnities payable under this
21 policy for any loss, other than a loss for which this policy
22 provides any periodic payment, will be paid immediately on receipt
23 of due written proof of the loss. Subject to due written proof of
24 loss, all accrued indemnities for a loss for which this policy
25 provides periodic payment will be paid _____ (insert period for
26 payment) and any balance remaining unpaid on termination of
27 liability will be paid immediately on receipt of due written proof

1 of loss."

2 (b) The period for payment to be inserted in the clause
3 required by Subsection (a) may not be less frequent than monthly.

4 (c) The provision required by this section is not required
5 to be contained in a policy issued by a corporation operating under
6 Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

7 Sec. 1201.215. POLICY PROVISION: PAYMENT OF CLAIMS. (a)
8 Except as provided by Subsection (d), an individual accident and
9 health insurance policy must contain the following provision:

10 "Payment of Claims: Indemnity for loss of life will be
11 payable in accordance with the beneficiary designation and the
12 provisions respecting indemnity payments that may be prescribed in
13 this policy and effective at the time of payment. If such a
14 designation or provision is not then effective, the indemnity will
15 be payable to the insured's estate. Any other accrued indemnities
16 unpaid at the insured's death may, at the option of the insurer, be
17 paid either in accordance with the beneficiary designation or to
18 the insured's estate. All other indemnities will be payable to the
19 insured."

20 (b) An insurer may include with the provision required by
21 Subsection (a) one or both of the following provisions:

22 "If any indemnity of this policy is payable to the insured's
23 estate, or to an insured or beneficiary who is a minor or is
24 otherwise not competent to give a valid release, the insurer may pay
25 the indemnity, up to an amount not exceeding \$_____ (insert
26 amount), to any relative by blood or connection by marriage of the
27 insured or beneficiary who is considered by the insurer to be

1 equitably entitled to the indemnity. Any payment made by the
2 insurer in good faith in accordance with this provision fully
3 discharges the insurer to the extent of the payment."

4 "Subject to any written direction of the insured, in the
5 application or otherwise, all or a portion of any indemnity
6 provided by this policy on account of hospital, nursing, medical,
7 or surgical services may, at the insurer's option and unless the
8 insured requests otherwise in writing not later than the time of
9 filing proof of the loss, be paid directly to the hospital or person
10 providing the services. It is not required that the service be
11 provided by a particular hospital or person."

12 (c) The amount to be inserted in the clause permitted by
13 Subsection (b) may not exceed \$1,000.

14 (d) The provision required by Subsection (a) is not required
15 to be contained in a policy issued by a corporation operating under
16 Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

17 Sec. 1201.216. POLICY PROVISION: PHYSICAL EXAMINATIONS AND
18 AUTOPSY. An individual accident and health insurance policy must
19 contain the following provision:

20 "Physical Examinations and Autopsy: The insurer at its own
21 expense has the right and opportunity to conduct a physical
22 examination of the insured when and as often as the insurer
23 reasonably requires while a claim under the policy is pending and,
24 in case of death, to require that an autopsy be conducted if not
25 forbidden by law." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

26 Sec. 1201.217. POLICY PROVISION: LEGAL ACTIONS. An
27 individual accident and health insurance policy must contain the

1 following provision:

2 "Legal Actions: An action at law or in equity may not be
3 brought to recover on this policy before the 61st day after the date
4 written proof of loss has been provided in accordance with the
5 requirements of this policy. An action at law or in equity may not
6 be brought after the expiration of three years after the time
7 written proof of loss is required to be provided." (V.T.I.C. Art.
8 3.70-3, Sec. (A) (part).)

9 Sec. 1201.218. POLICY PROVISION: CHANGE OF BENEFICIARY.

10 (a) Except as provided by Subsection (b), an individual accident
11 and health insurance policy must contain the following provision:

12 "Change of Beneficiary: Unless the insured makes an
13 irrevocable designation of beneficiary, the right to change a
14 beneficiary is reserved for the insured, and the consent of the
15 beneficiary or beneficiaries is not required for the surrender or
16 assignment of this policy, for any change of beneficiary or
17 beneficiaries, or for any other changes in this policy."

18 (b) An insurer may omit the first clause of the provision
19 required by Subsection (a) relating to an irrevocable designation
20 of beneficiary. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

21 Sec. 1201.219. POLICY PROVISION: CHANGE OF OCCUPATION. An
22 individual accident and health insurance policy must contain the
23 following provision if the policy addresses the subject matter of
24 the provision:

25 "Change of Occupation: If the insured is injured or
26 contracts a sickness after the insured changes the insured's
27 occupation to one classified by the insurer as more hazardous than

1 the occupation stated in this policy or while doing for
2 compensation anything pertaining to an occupation so classified,
3 the insurer will pay only the portion of the indemnity provided in
4 this policy as the premium paid would have purchased at the rates
5 and within the limits fixed by the insurer for the more hazardous
6 occupation. If the insured changes the insured's occupation to one
7 classified by the insurer as less hazardous than the occupation
8 stated in this policy, the insurer, on receipt of proof of the
9 change of occupation, will reduce the premium rate accordingly, and
10 will return the excess pro rata unearned premium from the date of
11 change of occupation or from the policy anniversary date
12 immediately preceding the receipt of the proof, whichever date is
13 more recent. In applying this provision, the classification of
14 occupational risk and the premium rates are the classification and
15 rates that, before the occurrence of the loss for which the insurer
16 is liable or before the date of proof of change in occupation, were:

17 (1) last filed by the insurer with the state official
18 having supervision of insurance in the state where the insured
19 resided at the time this policy was issued; or

20 (2) if filing was not required, last made effective by
21 the insurer in the state where the insured resided at the time this
22 policy was issued." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

23 Sec. 1201.220. POLICY PROVISION: MISSTATEMENT OF AGE. An
24 individual accident and health insurance policy must contain the
25 following provision if the policy addresses the subject matter of
26 the provision:

27 "Misstatement of Age: If the age of the insured has been

1 misstated, the amounts payable under this policy are the amounts
2 the premium paid would have purchased at the correct age."
3 (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

4 Sec. 1201.221. POLICY PROVISION: EXCESS INSURANCE. An
5 individual accident and health insurance policy must contain one of
6 the following provisions if the policy addresses the subject matter
7 of the provision:

8 "Other Insurance With This Insurer: If an accident or health
9 or accident and health policy or policies previously issued by the
10 insurer to the insured is in force concurrently with this policy,
11 making the aggregate indemnity for _____ (insert types of
12 coverages) in excess of \$_____ (insert maximum limit of indemnity
13 or indemnities), the excess insurance is void and all premiums paid
14 for the excess shall be returned to the insured or to the insured's
15 estate."

16 "Other Insurance With This Insurer: Insurance effective at
17 any one time on the insured under the same type of policy or
18 policies with this insurer is limited to the one policy elected by
19 the insured, the insured's beneficiary, or the insured's estate, as
20 the case may be, and the insurer will return all premiums paid for
21 all other policies of the same type." (V.T.I.C. Art. 3.70-3, Sec.
22 (B) (part).)

23 Sec. 1201.222. POLICY PROVISION: RELATION OF EARNINGS TO
24 INSURANCE. (a) Subject to Subsection (b), an individual accident
25 and health insurance policy must contain the following provision if
26 the policy addresses the subject matter of the provision:

27 "Relation of Earnings to Insurance: If the total monthly

1 amount of loss of time benefits promised for the same loss under all
2 valid loss of time coverage on the insured, regardless of whether
3 the benefits are payable on a weekly or monthly basis, exceeds the
4 amount of monthly earnings of the insured at the time the insured's
5 disability began or the insured's average amount of monthly
6 earnings for the period of two years immediately preceding a
7 disability for which claim is made, whichever amount is greater,
8 the insurer will be liable only for the proportionate amount of loss
9 of time benefits under this policy as the amount of the insured's
10 monthly earnings or average monthly earnings bears to the total
11 amount of monthly benefits for the same loss under all loss of time
12 coverage on the insured at the time the disability begins and for
13 the return of the part of the premiums paid during the immediately
14 preceding two years that exceeds the pro rata amount of the premiums
15 for the benefits actually paid under this policy. This provision
16 does not reduce the total monthly amount of benefits payable under
17 all loss of time coverage on the insured to less than \$200 or the sum
18 of the monthly benefits specified in the loss of time coverages,
19 whichever amount is less, and does not reduce benefits other than
20 loss of time benefits."

21 (b) The provision described by Subsection (a) may be
22 included only in a policy that provides that the insured is entitled
23 to continue the policy in force subject to its terms by the timely
24 payment of premiums until the insured reaches at least 50 years of
25 age or, if the policy was issued after the insured reached 44 years
26 of age, until at least the fifth anniversary of the policy's date of
27 issuance.

1 (c) An insurer may include in the provision described by
2 Subsection (a) a definition of "valid loss of time coverage." The
3 form of the definition must be approved by the commissioner. The
4 subject matter of the definition must be limited to:

5 (1) coverage provided by:

6 (A) governmental agencies; or

7 (B) organizations subject to regulation by
8 insurance laws or by insurance authorities of this or any other
9 state or any province of Canada;

10 (2) any other coverage the inclusion of which is
11 approved by the commissioner; or

12 (3) any combination of coverages described by
13 Subdivisions (1) and (2).

14 (d) In the absence of a definition authorized under
15 Subsection (c), "valid loss of time coverage" does not include:

16 (1) coverage provided for the insured under a
17 compulsory benefit statute, including a workers' compensation or
18 employer's liability statute; or

19 (2) benefits provided by:

20 (A) a union welfare plan;

21 (B) an employer benefit organization; or

22 (C) an employee benefit organization. (V.T.I.C.
23 Art. 3.70-3, Sec. (B) (part).)

24 Sec. 1201.223. POLICY PROVISION: UNPAID PREMIUM. An
25 individual accident and health insurance policy must contain the
26 following provision if the policy addresses the subject matter of
27 the provision:

1 "Unpaid Premium: At the time of payment of a claim under this
2 policy, any premium then due and unpaid or covered by any note or
3 written order may be deducted from the payment." (V.T.I.C. Art.
4 3.70-3, Sec. (B) (part).)

5 Sec. 1201.224. POLICY PROVISION: CANCELLATION. An
6 individual accident and health insurance policy must contain the
7 following provision if the policy addresses the subject matter of
8 the provision:

9 "Cancellation: The insurer may cancel this policy at any
10 time by written notice delivered to the insured, or mailed to the
11 insured's last address as shown by the records of the insurer,
12 stating when the cancellation is effective, which may not be
13 earlier than five days after the date the notice is delivered or
14 mailed. After this policy has been continued beyond its original
15 term, the insured may cancel the policy at any time by written
16 notice delivered or mailed to the insurer, effective on receipt or
17 on a later date specified in the notice. In the event of
18 cancellation, the insurer will promptly return the unearned portion
19 of any premium paid. If the insured cancels, the earned premium
20 shall be computed by the use of the short-rate table last filed with
21 the state official having supervision of insurance in the state
22 where the insured resided when the policy was issued. If the
23 insurer cancels, the earned premium shall be computed pro rata.
24 Cancellation is without prejudice to any claim originating before
25 the effective date of cancellation." (V.T.I.C. Art. 3.70-3, Sec.
26 (B) (part).)

27 Sec. 1201.225. POLICY PROVISION: CONFORMITY WITH STATE

1 STATUTES. An individual accident and health insurance policy must
2 contain the following provision if the policy addresses the subject
3 matter of the provision:

4 "Conformity With State Statutes: Any provision of this
5 policy that, on its effective date, conflicts with the statutes of
6 the state in which the insured resides on the effective date is by
7 this clause effectively amended to conform to the minimum
8 requirements of that state's statutes." (V.T.I.C. Art. 3.70-3,
9 Sec. (B) (part).)

10 Sec. 1201.226. POLICY PROVISION: ILLEGAL OCCUPATION. An
11 individual accident and health insurance policy must contain the
12 following provision if the policy addresses the subject matter of
13 the provision:

14 "Illegal Occupation: The insurer is not liable for any loss
15 to which a contributing cause was the insured's commission of or
16 attempt to commit a felony or to which a contributing cause was the
17 insured's being engaged in an illegal occupation." (V.T.I.C. Art.
18 3.70-3, Sec. (B) (part).)

19 Sec. 1201.227. POLICY PROVISION: INTOXICANTS AND
20 NARCOTICS. An individual accident and health insurance policy must
21 contain the following provision if the policy addresses the subject
22 matter of the provision:

23 "Intoxicants and Narcotics: The insurer is not liable for
24 any loss sustained or contracted in consequence of the insured's
25 being intoxicated or under the influence of any narcotic unless the
26 narcotic is administered on the advice of a physician." (V.T.I.C.
27 Art. 3.70-3, Sec. (B) (part).)

[Sections 1201.228-1201.270 reserved for expansion]

SUBCHAPTER F. APPLICATION FOR POLICY

Sec. 1201.271. ALTERATION OF POLICY APPLICATION. (a) A person may not alter a written application for an individual accident and health insurance policy unless the person has the written consent of the applicant.

(b) Notwithstanding Subsection (a), an insurer may make an insertion to an application solely for administrative purposes in a manner that indicates clearly that the insertion is not attributed to the applicant. (V.T.I.C. Art. 3.70-5, Sec. (B).)

Sec. 1201.272. FALSE STATEMENTS. The falsity of a statement in an application for an individual accident and health insurance policy does not bar a right to recovery under the policy unless the statement materially affected the acceptance of the risk or the hazard assumed by the insurer. (V.T.I.C. Art. 3.70-5, Sec. (C).)

Sec. 1201.273. BINDING STATEMENTS. An insured may not be bound by a statement made in an application for an individual accident and health insurance policy unless a copy of the application is attached to or endorsed on the policy as a part of the policy when issued. (V.T.I.C. Art. 3.70-5, Sec. (A) (part).)

Sec. 1201.274. INSURER'S EVIDENTIARY USE OF APPLICATION FOR REINSTATEMENT OR RENEWAL. (a) If an individual accident and health insurance policy is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes a written request for a copy of the application for reinstatement or renewal, the insurer shall, not later than the 15th day after the date the insurer

1 receives the request at its home or branch office, deliver or mail a
2 copy of the application to the person who made the request.

3 (b) An insurer that fails to comply with this section may
4 not introduce the application for reinstatement or renewal as
5 evidence in any action or proceeding based on or involving the
6 policy or its reinstatement or renewal. (V.T.I.C. Art. 3.70-5,
7 Sec. (A) (part).)

8 [Sections 1201.275-1201.700 reserved for expansion]

9 SUBCHAPTER O. ENFORCEMENT

10 Sec. 1201.701. CIVIL PENALTY. A person, partnership, or
11 corporation that wilfully violates this chapter or an order of the
12 commissioner made under this chapter is liable to the state for a
13 civil penalty in an amount not to exceed \$5,000 for each violation.
14 The penalty may be recovered through a civil action. (V.T.I.C. Art.
15 3.70-9 (part).)

16 Sec. 1201.702. ACTION AGAINST CERTIFICATE OF AUTHORITY OR
17 LICENSE. The commissioner may suspend or revoke the certificate of
18 authority or license of an insurer or agent who wilfully violates
19 this chapter or an order of the commissioner made under this
20 chapter. (V.T.I.C. Art. 3.70-9 (part).)

21 CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES

22 IN GENERAL

23 SUBCHAPTER A. CONTINUOUS POLICIES

24 Sec. 1202.001. CONTINUOUS POLICIES

25 [Sections 1202.002-1202.050 reserved for expansion]

26 SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

27 Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL

HEALTH INSURANCE POLICIES

Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV

CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES

IN GENERAL

SUBCHAPTER A. CONTINUOUS POLICIES

Sec. 1202.001. CONTINUOUS POLICIES. (a) A guaranteed renewable insurance policy or a noncancellable insurance policy is considered to be a continuous policy, subject only to the policy terms and conditions, including payment of the policy premium.

(b) A guaranteed renewable insurance policy or a noncancellable insurance policy:

(1) is continued in effect by the payment of the policy premium in accordance with the policy terms and conditions; and

(2) may not be considered or treated as a renewed policy by the payment of the policy premium.

(c) This section does not apply to a small employer health benefit plan adopted in accordance with Chapter 1501. (V.T.I.C. Art. 3.70-13.)

[Sections 1202.002-1202.050 reserved for expansion]

SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL HEALTH INSURANCE POLICIES. (a) This section applies only to an individual health insurance policy that provides benefits for medical care under a hospital, medical, or surgical policy.

(b) Except as provided by Subsection (c), an insurer shall renew or continue an individual health insurance policy at the option of the individual.

1 (c) An insurer may decline to renew or continue an
2 individual health insurance policy:

3 (1) for failure to pay a premium or contribution in
4 accordance with the terms of the policy;

5 (2) for fraud or intentional misrepresentation;

6 (3) because the insurer is ceasing to offer coverage
7 in the individual market in accordance with rules adopted by the
8 commissioner;

9 (4) because an individual no longer resides, lives, or
10 works in an area in which the insurer is authorized to provide
11 coverage, but only if all policies are not renewed or not continued
12 under this subdivision uniformly without regard to any
13 health-status related factor of covered individuals; or

14 (5) in accordance with federal law, including
15 regulations.

16 (d) The commissioner shall adopt rules necessary to:

17 (1) implement this section; and

18 (2) meet the minimum requirements of federal law,
19 including regulations. (V.T.I.C. Art. 3.70-1A.)

20 Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV.

21 (a) In this section, "AIDS" and "HIV" have the meanings assigned by
22 Section 81.101, Health and Safety Code.

23 (b) Except as provided by Subsection (c), an insurer that
24 delivers or issues for delivery an individual accident and health
25 insurance policy in this state may not cancel that policy during its
26 term because the insured:

27 (1) has been diagnosed as having AIDS or HIV;

(2) has been treated for AIDS or HIV; or

(3) is being treated for AIDS or HIV.

(c) The insurer may cancel the policy for:

(1) failure to pay a premium when due; or

(2) fraud or misrepresentation in obtaining coverage by not disclosing a diagnosis of an AIDS or HIV-related condition.

(d) The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this section. (V.T.I.C. Art. 3.70-3A; New.)

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

Sec. 1203.001. APPLICABILITY OF CHAPTER

Sec. 1203.002. CERTAIN COORDINATION OF BENEFITS PROVISIONS

PROHIBITED

Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS

VOID

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

Sec. 1203.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to:

(1) a policy of group accident and health insurance as described by Chapter 1251;

(2) a policy of blanket accident and health insurance as described by Chapter 1251;

(3) a policy of individual accident and health insurance as defined by Section 1201.001; or

(4) an evidence of coverage as defined by Section

1 843.002.

2 (b) This chapter does not apply to an individual accident
3 and health insurance policy that is designed to fully integrate
4 with other policies through a variable deductible. (V.T.I.C. Art.
5 3.51-6B, Sec. 1(a) (part).)

6 Sec. 1203.002. CERTAIN COORDINATION OF BENEFITS PROVISIONS
7 PROHIBITED. (a) An accident and health insurance policy or
8 evidence of coverage may not be delivered, issued for delivery, or
9 renewed in this state if:

10 (1) a provision of the policy or evidence of coverage
11 excludes or reduces the payment of benefits to or on behalf of an
12 insured or enrollee;

13 (2) the reason for the exclusion or reduction is that
14 benefits are also payable or have been paid to or on behalf of the
15 insured or enrollee under a supplemental policy of accident and
16 health insurance; and

17 (3) the supplemental policy is individually
18 underwritten and individually issued as a plan of coverage for:

19 (A) hospital confinement indemnity;

20 (B) a specified disease; or

21 (C) a limited benefit.

22 (b) Application of Subsection (a) to a provision of an
23 accident and health insurance policy or evidence of coverage is not
24 affected by:

25 (1) the mode or channel by which the premium for a
26 supplemental policy of accident and health insurance is paid to the
27 insurer; or

1 (2) a reduction in the premium for a supplemental
2 policy of accident and health insurance because of the insured's
3 membership in an organization or status as an employee. (V.T.I.C.
4 Art. 3.51-6B, Secs. 1(a) (part), (b).)

5 Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS
6 VOID. A provision of an accident and health insurance policy or
7 evidence of coverage that violates Section 1203.002 is void.
8 (V.T.I.C. Art. 3.51-6B, Sec. 2.)

9 CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND

10 ACCIDENT INSURANCE POLICY OR PLAN BENEFITS

11 SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

12 Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES

13 Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED

14 BY HOSPITAL OWNED BY STATE OR UNIT OF LOCAL

15 GOVERNMENT

16 [Sections 1204.003-1204.050 reserved for expansion]

17 SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

18 Sec. 1204.051. DEFINITIONS

19 Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS

20 OR PROGRAMS

21 Sec. 1204.053. ASSIGNMENT OF BENEFITS

22 Sec. 1204.054. PAYMENT OF BENEFITS ACCORDING TO ASSIGNMENT

23 Sec. 1204.055. CONTRACTUAL RESPONSIBILITY FOR DEDUCTIBLES

24 AND COPAYMENTS

25 [Sections 1204.056-1204.100 reserved for expansion]

26 SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

27 Sec. 1204.101. DEFINITIONS

1 Sec. 1204.102. REQUIRED CLAIM BILLING FORMS

2 [Sections 1204.103-1204.150 reserved for expansion]

3 SUBCHAPTER D. PAYMENTS FOR CERTAIN PUBLICLY PROVIDED SERVICES

4 Sec. 1204.151. DEFINITION

5 Sec. 1204.152. PAYMENT FOR CERTAIN EXPENSES INCURRED BY
6 TEXAS DEPARTMENT OF HUMAN SERVICES

7 Sec. 1204.153. PAYMENTS TO TEXAS DEPARTMENT OF HUMAN
8 SERVICES FOR CERTAIN CHILDREN

9 Sec. 1204.154. UNIFORM PROVISIONS

10 [Sections 1204.155-1204.200 reserved for expansion]

11 SUBCHAPTER E. EXCLUSIONARY CLAUSES

12 Sec. 1204.201. PROHIBITION OF EXCLUSION OF CERTAIN
13 MEDICAL ASSISTANCE BENEFITS

14 [Sections 1204.202-1204.250 reserved for expansion]

15 SUBCHAPTER F. PAYMENT OF BENEFITS TO CONSERVATOR OF MINOR

16 Sec. 1204.251. PAYMENT TO CONSERVATOR OTHER THAN
17 GROUP MEMBER

18 Sec. 1204.252. PRECONDITIONS FOR PAYMENT; EXCEPTIONS

19 Sec. 1204.253. RULES

20 CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND
21 ACCIDENT INSURANCE POLICY OR PLAN BENEFITS

22 SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

23 Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES.

24 This subchapter does not apply to indigent care or chronic disease
25 care provided in or by an eleemosynary institution, sanitarium,
26 sanitorium, mental health treatment facility, tuberculosis
27 treatment facility, or cancer treatment facility that is owned or

1 controlled by the state or by a unit of local government. (V.T.I.C.
2 Art. 3.42B (part).)

3 Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY
4 HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT. An insurance
5 policy providing hospital, nursing, medical, or surgical coverage
6 that is issued or delivered in this state after August 27, 1973, may
7 not include a provision that prevents the payment of benefits for
8 expenses of a nonindigent patient incurred in a hospital facility
9 that:

10 (1) is owned or controlled by the state or by a unit of
11 local government; and

12 (2) regularly and customarily demands and collects
13 from nonindigent persons payment for those expenses. (V.T.I.C.
14 Art. 3.42B (part).)

15 [Sections 1204.003-1204.050 reserved for expansion]

16 SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

17 Sec. 1204.051. DEFINITIONS. In this subchapter:

18 (1) "Covered person" means a person who is insured or
19 covered by a health insurance policy or is a participant in an
20 employee benefit plan. The term includes:

21 (A) a person covered by a health insurance policy
22 because the person is an eligible dependent; and

23 (B) an eligible dependent of a participant in an
24 employee benefit plan.

25 (2) "Employee benefit plan" or "plan" means a plan,
26 fund, or program established or maintained by an employer, an
27 employee organization, or both, to the extent that it provides,

1 through the purchase of insurance or otherwise, health care
2 services to employees, participants, or the dependents of employees
3 or participants.

4 (3) "Health care provider" means a person who provides
5 health care services under a license, certificate, registration, or
6 other similar evidence of regulation issued by this or another
7 state of the United States.

8 (4) "Health care service" means a service to diagnose,
9 prevent, alleviate, cure, or heal a human illness or injury that is
10 provided to a covered person by a physician or other health care
11 provider.

12 (5) "Health insurance policy" means an individual,
13 group, blanket, or franchise insurance policy, or an insurance
14 agreement, that provides reimbursement or indemnity for health care
15 expenses incurred as a result of an accident or sickness.

16 (6) "Insurer" means an insurance company,
17 association, or organization authorized to engage in business in
18 this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886,
19 887, 888, 941, 942, or 982.

20 (7) "Person" means an individual, association,
21 partnership, corporation, or other legal entity.

22 (8) "Physician" means an individual licensed to
23 practice medicine in this or another state of the United States.

24 (V.T.I.C. Art. 21.24-1, Sec. 1; New.)

25 Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR PROGRAMS.
26 This subchapter applies to:

27 (1) an employee benefit plan, to the extent not

preempted by the Employee Retirement Income Security Act of 1974
(29 U.S.C. Section 1001 et seq.);

(2) benefit programs under Chapters 1551 and 1601, to
the extent that the benefit programs are self-insuring; and

(3) insurance coverage provided under Chapter 1575.
(V.T.I.C. Art. 21.24-1, Sec. 2.)

Sec. 1204.053. ASSIGNMENT OF BENEFITS. (a) An insurer may
not deliver, renew, or issue for delivery in this state a health
insurance policy that prohibits or restricts a covered person from
making a written assignment of benefits to a physician or other
health care provider who provides health care services to the
person.

(b) This section does not:

(1) provide a coverage or benefit that is not
otherwise available under the health insurance policy;

(2) allow assignment of a benefit to:

(A) a person who is not legally entitled to
receive such a direct payment; or

(B) another person if, under the health insurance
policy or plan, the benefit must be provided to the covered person
by a physician or other health care provider who is a contractor or
preferred provider under the policy; or

(3) prohibit an insurer from verifying, through the
insurer's normal process, the health care services the physician or
other health care provider provides to the covered person.
(V.T.I.C. Art. 21.24-1, Sec. 3.)

Sec. 1204.054. PAYMENT OF BENEFITS ACCORDING TO ASSIGNMENT.

1 An insurer shall pay benefits directly to a physician or other
2 health care provider, and the insurer is relieved of the obligation
3 to pay, and of any liability for paying, those benefits to the
4 covered person if:

5 (1) the covered person makes a written assignment of
6 those benefits payable to the physician or other health care
7 provider; and

8 (2) the assignment is obtained by or delivered to the
9 insurer with the claim for benefits. (V.T.I.C. Art. 21.24-1, Secs.
10 4(a), (b).)

11 Sec. 1204.055. CONTRACTUAL RESPONSIBILITY FOR DEDUCTIBLES
12 AND COPAYMENTS. (a) The payment of benefits under an assignment
13 does not relieve a covered person of a contractual obligation to pay
14 a deductible or copayment.

15 (b) A physician or other health care provider may not waive
16 a deductible or copayment by the acceptance of an assignment.
17 (V.T.I.C. Art. 21.24-1, Sec. 4(c).)

18 [Sections 1204.056-1204.100 reserved for expansion]

19 SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

20 Sec. 1204.101. DEFINITIONS. In this subchapter:

21 (1) "Health benefit plan" means a group, blanket, or
22 franchise insurance policy, a group hospital service contract, or a
23 group subscriber contract or evidence of coverage issued by a
24 health maintenance organization, that provides benefits for health
25 care services.

26 (2) "Health benefit plan issuer" means an entity
27 authorized under this code or another insurance law of this state

1 that provides health insurance or health benefits in this state,
2 including:

3 (A) an insurance company;

4 (B) a group hospital service corporation
5 operating under Chapter 842;

6 (C) a health maintenance organization operating
7 under Chapter 843; and

8 (D) a stipulated premium company operating under
9 Chapter 884.

10 (3) "Provider" means a person who provides health care
11 under a license issued by this state. The term includes a health
12 care practitioner listed in Section 1451.001 and a nurse first
13 assistant, as defined by Section 1451.101. (V.T.I.C. Art. 21.52C,
14 Sec. (a).)

15 Sec. 1204.102. REQUIRED CLAIM BILLING FORMS. A provider
16 who seeks payment or reimbursement under a health benefit plan and
17 the health benefit plan issuer that issued the plan shall use
18 uniform claim billing form UB-82/HCFR or HCFR 1500, or a successor
19 to one of those forms, as developed by the National Uniform Billing
20 Committee or its successor. (V.T.I.C. Art. 21.52C, Sec. (b).)

21 [Sections 1204.103-1204.150 reserved for expansion]

22 SUBCHAPTER D. PAYMENTS FOR CERTAIN PUBLICLY PROVIDED SERVICES

23 Sec. 1204.151. DEFINITION. In this subchapter, "policy"
24 means an individual or group policy of accident and health
25 insurance, including a policy issued by a group hospital service
26 corporation operating under Chapter 842. (V.T.I.C. Art. 3.76, Sec.
27 1 (part); Art. 21.49-10 (part).)

1 Sec. 1204.152. PAYMENT FOR CERTAIN EXPENSES INCURRED BY
2 TEXAS DEPARTMENT OF HUMAN SERVICES. Each policy delivered or
3 issued for delivery in this state must provide for the repayment of
4 the actual costs of medical expenses the Texas Department of Human
5 Services pays through medical assistance for an insured person if,
6 under the policy, the insured person is entitled to payment for the
7 medical expenses. (V.T.I.C. Art. 21.49-10 (part).)

8 Sec. 1204.153. PAYMENTS TO TEXAS DEPARTMENT OF HUMAN
9 SERVICES FOR CERTAIN CHILDREN. (a) This section applies only to a
10 policy that is delivered, issued for delivery, or renewed in this
11 state and that provides coverage for a child whose parent:

12 (1) purchased the policy; or

13 (2) is a member of the group covered under the policy.

14 (b) Each policy must include a requirement that, after
15 written notice to the insurer or group hospital service corporation
16 at the insurer's or group hospital service corporation's home
17 office, benefits payable on behalf of a child must be paid to the
18 Texas Department of Human Services if:

19 (1) the parent who purchased the policy or who is a
20 group member is required to pay child support by a court order or
21 court-approved agreement and:

22 (A) is a possessory conservator of the child
23 under a court order issued in this state; or

24 (B) is not entitled to possession of or access to
25 the child;

26 (2) the Texas Department of Human Services is paying
27 benefits on behalf of the child under Chapter 31 or 32, Human

Resources Code; and

(3) the insurer or group hospital service corporation is notified, through an attachment to the claim for benefits at the time the claim is first submitted to the insurer or group hospital service corporation, that the benefits must be paid directly to the Texas Department of Human Services.

(c) The commissioner and the Texas Department of Human Services may consult regarding implementation of this section. (V.T.I.C. Art. 3.76, Secs. 1 (part), 2.)

Sec. 1204.154. UNIFORM PROVISIONS. (a) The commissioner shall adopt uniform policy provisions, riders, and endorsements for the policy requirement of Section 1204.153.

(b) Before the commissioner adopts or makes a change to a provision, rider, or endorsement under Subsection (a), the commissioner shall present each provision, rider, or endorsement, and any amendment to a provision, rider, or endorsement, to the Texas Department of Human Services for comment. (V.T.I.C. Art. 3.76, Sec. 3.)

[Sections 1204.155-1204.200 reserved for expansion]

SUBCHAPTER E. EXCLUSIONARY CLAUSES

Sec. 1204.201. PROHIBITION OF EXCLUSION OF CERTAIN MEDICAL ASSISTANCE BENEFITS. An individual or group accident and health insurance policy delivered or issued for delivery in this state, including a policy issued by a group hospital service corporation operating under Chapter 842, may not include a provision that excludes or limits the insurer's or group hospital service corporation's coverage from paying benefits covered by Chapter 32,

Human Resources Code. (V.T.I.C. Art. 21.49-9.)

[Sections 1204.202-1204.250 reserved for expansion]

SUBCHAPTER F. PAYMENT OF BENEFITS TO CONSERVATOR OF MINOR

Sec. 1204.251. PAYMENT TO CONSERVATOR OTHER THAN GROUP MEMBER. (a) An insurer or group hospital service corporation operating under Chapter 842 that delivers, issues for delivery, or renews in this state a group accident and health insurance policy that provides coverage for a minor child who qualifies as a dependent of a group member may pay benefits on the child's behalf to a person who is not a group member if an order providing for the appointment of a possessory or managing conservator of the child has been issued by a court in this or another state.

(b) A person who is not a group member is entitled to be paid benefits under this section only if the person presents to the insurer or group hospital service corporation, with the claim application:

(1) written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and

(2) a certified copy of a court order designating the person as possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the benefits as this section provides. (V.T.I.C. Art. 3.51-13, Secs. 1, 3.)

Sec. 1204.252. PRECONDITIONS FOR PAYMENT; EXCEPTIONS. (a) In accordance with the terms of the policy and this subchapter, an insurer or group hospital service corporation may be required to

1 pay benefits under a group accident and health insurance policy to a
2 person who is not a group member and who complies with:

3 (1) Section 1204.251;

4 (2) the insurer's or group hospital service
5 corporation's claim application procedures; and

6 (3) department rules.

7 (b) Any requirement imposed on a possessory or managing
8 conservator of a child under this subchapter does not apply with
9 regard to:

10 (1) an unpaid medical bill for which an assignment of
11 benefits has been exercised, whether in accordance with policy
12 provisions or otherwise; or

13 (2) a claim presented by a group member for which the
14 group member paid any portion of a medical bill that is covered
15 under the policy's terms. (V.T.I.C. Art. 3.51-13, Sec. 2.)

16 Sec. 1204.253. RULES. The commissioner may adopt rules to
17 ensure the effective implementation of this subchapter. (V.T.I.C.
18 Art. 3.51-13, Sec. 4.)

19 CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

20 Sec. 1205.001. APPLICABILITY OF CHAPTER

21 Sec. 1205.002. CERTIFICATION OF COVERAGE

22 Sec. 1205.003. RULES

23 Sec. 1205.004. CREDITABLE COVERAGE

24 CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

25 Sec. 1205.001. APPLICABILITY OF CHAPTER. This chapter
26 applies only to a health benefit plan that:

27 (1) provides benefits for medical or surgical expenses

1 incurred as a result of a health condition, accident, or sickness,
2 including:

3 (A) an individual, group, blanket, or franchise
4 insurance policy or insurance agreement, a group hospital service
5 contract, or an individual or group evidence of coverage that is
6 offered by:

7 (i) an insurance company;

8 (ii) a group hospital service corporation
9 operating under Chapter 842;

10 (iii) a fraternal benefit society operating
11 under Chapter 885;

12 (iv) a stipulated premium company operating
13 under Chapter 884; or

14 (v) a health maintenance organization
15 operating under Chapter 843; and

16 (B) to the extent permitted by the Employee
17 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
18 seq.), a health benefit plan that is offered by:

19 (i) a multiple employer welfare arrangement
20 as defined by Section 3 of that Act and operating under Chapter 846;
21 or

22 (ii) an analogous benefit arrangement;

23 (2) is offered by an approved nonprofit health
24 corporation that holds a certificate of authority under Chapter
25 844; or

26 (3) is offered by any other entity that:

27 (A) is not authorized under this code or another

1 insurance law of this state; and

2 (B) contracts directly for health care services
3 on a risk-sharing basis, including a capitation basis. (V.T.I.C.
4 Art. 21.52G, Sec. 2, as added Acts 75th Leg., R.S., Ch. 955.)

5 Sec. 1205.002. CERTIFICATION OF COVERAGE. (a) A health
6 benefit plan issuer shall provide a certification of coverage as
7 necessary to determine the period of applicable creditable coverage
8 under that health benefit plan.

9 (b) The certification required under this section must be
10 provided in accordance with the standards adopted by rule by the
11 commissioner. (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th
12 Leg., R.S., Ch. 955.)

13 Sec. 1205.003. RULES. The commissioner shall adopt rules
14 as necessary to:

15 (1) implement this chapter and related provisions of
16 this code; and

17 (2) meet the minimum requirements of federal law,
18 including regulations. (V.T.I.C. Art. 21.52G, Sec. 5, as added
19 Acts 75th Leg., R.S., Ch. 955.)

20 Sec. 1205.004. CREDITABLE COVERAGE. (a) An individual's
21 coverage is creditable coverage for purposes of this chapter if the
22 coverage is provided under:

23 (1) a self-funded or self-insured employee welfare
24 benefit plan that:

25 (A) provides health benefits; and

26 (B) is established in accordance with the
27 Employee Retirement Income Security Act of 1974 (29 U.S.C. Section

1001 et seq.);

(2) a group health benefit plan provided by a health insurer or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that act (42 U.S.C. Section 1396s);

(6) 10 U.S.C. Section 1071 et seq.;

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state health benefits risk pool;

(9) a health plan offered under 5 U.S.C. Section 8901 et seq.;

(10) a public health plan as defined by federal regulations; or

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)).

(b) For purposes of this chapter, creditable coverage does not include:

(1) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance, including general liability

1 insurance and automobile liability insurance;

2 (4) workers' compensation insurance or other similar
3 insurance;

4 (5) automobile medical payment insurance;

5 (6) credit-only insurance;

6 (7) coverage for on-site medical clinics;

7 (8) other coverage that is:

8 (A) similar to the coverage described by this
9 subsection under which benefits for medical care are secondary or
10 incidental to other insurance benefits; and

11 (B) specified by federal regulations;

12 (9) coverage that provides limited-scope dental or
13 vision benefits;

14 (10) long-term care, nursing home care, home health
15 care, or community-based care coverage or benefits or any
16 combination of those coverages or benefits;

17 (11) coverage that provides other limited benefits
18 specified by federal regulations;

19 (12) coverage for a specified disease or illness;

20 (13) hospital indemnity or other fixed indemnity
21 insurance; or

22 (14) Medicare supplemental health insurance, as
23 defined by Section 1882(g)(1), Social Security Act (42 U.S.C.
24 Section 1395ss), coverage supplemental to the coverage provided
25 under 10 U.S.C. Section 1071 et seq., or other similar supplemental
26 coverage provided under a group plan. (V.T.I.C. Art. 21.52G, Sec.
27 3, as added Acts 75th Leg., R.S., Ch. 955.)

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT

BASED ON EXISTING COVERAGE PROHIBITED

Sec. 1206.001. APPLICABILITY OF CHAPTER

Sec. 1206.002. EXCEPTION

Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED

Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR DISCRIMINATION

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT

BASED ON EXISTING COVERAGE PROHIBITED

Sec. 1206.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

1 (7) a multiple employer welfare arrangement that holds
2 a certificate of authority under Chapter 846; or

3 (8) an approved nonprofit health corporation that
4 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
5 21.52L, Secs. 1(a), (b), as added Acts 77th Leg., R.S., Ch. 1074.)

6 Sec. 1206.002. EXCEPTION. This chapter does not apply to:

7 (1) a plan that provides coverage:

8 (A) only for a specified disease or for another
9 limited benefit;

10 (B) only for accidental death or dismemberment;

11 (C) for wages or payments in lieu of wages for a
12 period during which an employee is absent from work because of
13 sickness or injury;

14 (D) as a supplement to a liability insurance
15 policy;

16 (E) for credit insurance;

17 (F) only for dental or vision care;

18 (G) only for hospital expenses;

19 (H) only for indemnity for hospital confinement;

20 or

21 (I) in accordance with Title XXI of the Social
22 Security Act (42 U.S.C. Section 1397aa et seq.);

23 (2) a Medicare supplemental policy as defined by
24 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
25 as amended;

26 (3) a workers' compensation insurance policy;

27 (4) medical payment insurance coverage provided under

1 a motor vehicle insurance policy; or

2 (5) a long-term care insurance policy, including a
3 nursing home fixed indemnity policy, unless the commissioner
4 determines that the policy provides benefit coverage so
5 comprehensive that the policy is a health benefit plan as described
6 by Section 1206.001. (V.T.I.C. Art. 21.52L, Sec. 1(c), as added
7 Acts 77th Leg., R.S., Ch. 1074.)

8 Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED. A health
9 benefit plan issuer may not refuse to enroll an individual in the
10 plan solely because the individual is enrolled in another health
11 benefit plan at the time the individual applies for coverage under
12 the plan. (V.T.I.C. Art. 21.52L, Sec. 2, as added Acts 77th Leg.,
13 R.S., Ch. 1074.)

14 Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR
15 DISCRIMINATION. A health benefit plan issuer who violates this
16 chapter engages in unfair discrimination under Subchapter B,
17 Chapter 544. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th
18 Leg., R.S., Ch. 1074.)

19 CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS AND
20 CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

21 Sec. 1207.001. APPLICABILITY OF CHAPTER

22 Sec. 1207.002. ENROLLMENT REQUIRED

23 Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT

24 Sec. 1207.004. TERMINATION OF ENROLLMENT

25 CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS AND
26 CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

27 Sec. 1207.001. APPLICABILITY OF CHAPTER. This chapter

1 applies only to a group health benefit plan, including a small
2 employer health benefit plan written under Chapter 1501 or a plan
3 provided under Chapter 1551, 1575, or 1601, or a successor to a plan
4 provided under one of those chapters, that provides benefits for
5 medical or surgical expenses incurred as a result of a health
6 condition, accident, or sickness, including a group, blanket, or
7 franchise insurance policy or insurance agreement, a group hospital
8 service contract, or a group evidence of coverage or similar group
9 coverage document that is offered by:

- 10 (1) an insurance company;
- 11 (2) a group hospital service corporation operating
12 under Chapter 842;
- 13 (3) a fraternal benefit society operating under
14 Chapter 885;
- 15 (4) a stipulated premium company operating under
16 Chapter 884;
- 17 (5) a reciprocal exchange operating under Chapter 942;
- 18 (6) a health maintenance organization operating under
19 Chapter 843;
- 20 (7) a multiple employer welfare arrangement that holds
21 a certificate of authority under Chapter 846; or
- 22 (8) an approved nonprofit health corporation that
23 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
24 21.52K, Sec. 1.)

25 Sec. 1207.002. ENROLLMENT REQUIRED. (a) A group health
26 benefit plan issuer shall permit an individual who is otherwise
27 eligible for enrollment in the plan to enroll in the plan, without

1 regard to any enrollment period restriction, on receipt of written
2 notice from the Texas Department of Health or a designee of that
3 department stating that the individual is:

4 (1) a recipient of medical assistance under the state
5 Medicaid program and is a participant in the health insurance
6 premium payment reimbursement program under Section 32.0422, Human
7 Resources Code; or

8 (2) a child enrolled in the state child health plan
9 under Chapter 62, Health and Safety Code, and is a participant in
10 the health insurance premium payment reimbursement program under
11 Section 62.059, Health and Safety Code.

12 (b) If an individual described by Subsection (a)(1) or (2)
13 is not eligible to enroll in the group health benefit plan unless a
14 family member of the individual is also enrolled in the plan, the
15 plan issuer, on receipt of written notice under Subsection (a),
16 shall enroll both the individual and the family member in the plan.
17 (V.T.I.C. Art. 21.52K, Secs. 2(a), (b), (c).)

18 Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT. Unless
19 enrollment occurs during an established enrollment period,
20 enrollment in a group health benefit plan under Section 1207.002
21 takes effect on the first day of the calendar month that begins at
22 least 30 days after the date written notice is received by the plan
23 issuer under Section 1207.002(a). (V.T.I.C. Art. 21.52K, Sec.
24 2(d).)

25 Sec. 1207.004. TERMINATION OF ENROLLMENT. (a)
26 Notwithstanding any other requirement of a group health benefit
27 plan, the plan issuer shall permit an individual who is enrolled in

1 the plan under Section 1207.002(a)(1), and any family member of the
2 individual enrolled under Section 1207.002(b), to terminate
3 enrollment in the plan not later than the 60th day after the date on
4 which the individual provides satisfactory proof to the issuer that
5 the individual is no longer:

6 (1) a recipient of medical assistance under the state
7 Medicaid program; or

8 (2) a participant in the health insurance premium
9 payment reimbursement program under Section 32.0422, Human
10 Resources Code.

11 (b) Notwithstanding any other requirement of a group health
12 benefit plan, the plan issuer shall permit an individual who is
13 enrolled in the plan under Section 1207.002(a)(2), and any family
14 member of the individual enrolled under Section 1207.002(b), to
15 terminate enrollment in the plan not later than the 60th day after
16 the date on which the individual provides satisfactory proof to the
17 issuer that the child is no longer a participant in the health
18 insurance premium payment reimbursement program under Section
19 62.059, Health and Safety Code. (V.T.I.C. Art. 21.52K, Secs. 2(e),
20 (f).)

21 CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE

22 OF HEALTH BENEFIT PLAN ISSUER

23 Sec. 1208.001. APPLICABILITY OF CHAPTER

24 Sec. 1208.002. DISCLOSURE REQUIRED

25 CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE

26 OF HEALTH BENEFIT PLAN ISSUER

27 Sec. 1208.001. APPLICABILITY OF CHAPTER. This chapter

1 applies only to a health benefit plan that provides benefits for
2 medical or surgical expenses incurred as a result of a health
3 condition, accident, or sickness, including an individual, group,
4 blanket, or franchise insurance policy or insurance agreement, a
5 group hospital service contract, or an individual or group evidence
6 of coverage or similar coverage document that is offered by:

- 7 (1) an insurance company;
- 8 (2) a group hospital service corporation operating
9 under Chapter 842;
- 10 (3) a fraternal benefit society operating under
11 Chapter 885;
- 12 (4) a stipulated premium company operating under
13 Chapter 884;
- 14 (5) a reciprocal exchange operating under Chapter 942;
- 15 (6) a health maintenance organization operating under
16 Chapter 843;
- 17 (7) a multiple employer welfare arrangement that holds
18 a certificate of authority under Chapter 846; or
- 19 (8) an approved nonprofit health corporation that
20 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
21 21.24-3, Sec. 1.)

22 Sec. 1208.002. DISCLOSURE REQUIRED. After an oral or
23 written request by an insured or enrollee of a health benefit plan,
24 the plan issuer shall provide to the insured or enrollee the name or
25 employee identifier of the issuer's employee who is available to
26 respond to questions or other communication from the insured or
27 enrollee relating to coverage and benefits provided under the plan

1 to the insured or enrollee. The issuer shall also provide:

2 (1) the employee's mailing address;

3 (2) the municipality and state of the employee's
4 business location; and

5 (3) the employee's job title. (V.T.I.C. Art. 21.24-3,
6 Sec. 2.)

7 CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION

8 REQUIRED TO BE PROVIDED TO EMPLOYER

9 Sec. 1209.001. APPLICABILITY OF CHAPTER

10 Sec. 1209.002. CLAIMS COST INFORMATION

11 Sec. 1209.003. CONFIDENTIALITY

12 CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION

13 REQUIRED TO BE PROVIDED TO EMPLOYER

14 Sec. 1209.001. APPLICABILITY OF CHAPTER. This chapter
15 applies only to a group health benefit plan, including a small
16 employer health benefit plan written under Chapter 1501, that:

17 (1) provides benefits for medical or surgical expenses
18 incurred as a result of a health condition, accident, or sickness,
19 including a group, blanket, or franchise insurance policy or
20 insurance agreement, a group hospital service contract, or a group
21 evidence of coverage or similar group coverage document that is
22 offered by:

23 (A) an insurance company;

24 (B) a group hospital service corporation
25 operating under Chapter 842;

26 (C) a fraternal benefit society operating under
27 Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a reciprocal exchange operating under Chapter 942;

(F) a health maintenance organization operating under Chapter 843;

(G) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(H) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; and

(2) provides health benefits to the employees of one or more employers that sponsor the plan. (V.T.I.C. Art. 21.49-19, Secs. 1, 2.)

Sec. 1209.002. CLAIMS COST INFORMATION. (a) On the request of an employer sponsoring a group health benefit plan, the plan issuer shall provide to the employer the claims cost information for employees covered by the plan during the preceding calendar year.

(b) Claims cost information provided under this section:

(1) may be provided in the aggregate or on a detailed basis;

(2) must be provided separately for each month during which the group health benefit plan was in effect; and

(3) may not include information, including diagnosis code information, that may be used to identify a specific individual enrolled in the plan or a diagnosis of that individual. (V.T.I.C. Art. 21.49-19, Secs. 3(a), (b).)

1 Sec. 1209.003. CONFIDENTIALITY. Information obtained by an
2 employer under this chapter is confidential and may be used by the
3 employer only for purposes relating to obtaining or maintaining
4 group health benefit plan coverage for the employer's employees.
5 (V.T.I.C. Art. 21.49-19, Sec. 3(c).)

6 CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

7 Sec. 1210.001. NOTICE REQUIRED

8 CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

9 Sec. 1210.001. NOTICE REQUIRED. A policy, contract, or
10 certificate of insurance that insures against loss resulting from
11 sickness or accidental bodily injury and that is subject to an
12 increase in the premium at time of renewal or to nonrenewal on the
13 insured attaining a certain age may not be delivered, issued, or
14 used in this state unless the document contains on the first page
15 above the policy provisions a printed notice in 10-point type that
16 states that the policy, contract, or certificate is subject to
17 either or both conditions. (V.T.I.C. Art. 3.42-1, Secs. (a), (b).)

18 [Chapters 1211-1250 reserved for expansion]

19 SUBTITLE B. GROUP HEALTH COVERAGE

20 CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE

21 SUBCHAPTER A. GENERAL PROVISIONS

22 Sec. 1251.001. DEFINITIONS

23 Sec. 1251.002. CERTAIN GROUP HEALTH INSURANCE AUTHORIZED

24 Sec. 1251.003. CERTAIN BLANKET HEALTH INSURANCE

25 AUTHORIZED

26 Sec. 1251.004. CERTAIN PAYMENTS BY INSURERS PROHIBITED

27 Sec. 1251.005. PAYMENT OF BENEFITS

1 Sec. 1251.006. POLICY MAY NOT SPECIFY SERVICE PROVIDER

2 Sec. 1251.007. EXCEPTIONS

3 Sec. 1251.008. RULES

4 [Sections 1251.009-1251.050 reserved for expansion]

5 SUBCHAPTER B. GROUP ACCIDENT AND HEALTH INSURANCE:

6 ELIGIBLE POLICYHOLDERS

7 Sec. 1251.051. EMPLOYERS

8 Sec. 1251.052. ASSOCIATIONS

9 Sec. 1251.053. FUNDS ESTABLISHED BY EMPLOYERS, LABOR

10 UNIONS, OR ASSOCIATIONS

11 Sec. 1251.054. ELIGIBILITY FOR GROUP LIFE INSURANCE

12 Sec. 1251.055. FUND FOR FORMER EMPLOYEES AND MEMBERS

13 Sec. 1251.056. OTHER GROUPS

14 [Sections 1251.057-1251.100 reserved for expansion]

15 SUBCHAPTER C. GROUP ACCIDENT AND HEALTH INSURANCE:

16 REQUIRED PROVISIONS

17 Sec. 1251.101. REQUIRED PROVISIONS

18 Sec. 1251.102. PAYMENT OF PREMIUMS

19 Sec. 1251.103. INCONTESTABILITY OF POLICY

20 Sec. 1251.104. ENTIRE CONTRACT

21 Sec. 1251.105. STATEMENT MADE BY POLICYHOLDER

22 OR INSURED

23 Sec. 1251.106. DISTINCTION BASED ON MARITAL STATUS

24 PROHIBITED

25 Sec. 1251.107. EVIDENCE OF INSURABILITY

26 Sec. 1251.108. EXCLUSION OR LIMITATION OF COVERAGE FOR

27 PREEXISTING CONDITIONS

1 Sec. 1251.109. ADJUSTMENT OF PREMIUMS OR BENEFITS IF AGE OF

2 INSURED IS MISSTATED

3 Sec. 1251.110. DEADLINE FOR NOTICE OF CLAIM

4 Sec. 1251.111. CLAIM FORMS

5 Sec. 1251.112. DEADLINE FOR CLAIM

6 Sec. 1251.113. PROMPT PAYMENT OF BENEFITS REQUIRED

7 Sec. 1251.114. PAYMENT OF BENEFITS

8 Sec. 1251.115. RIGHT TO CONDUCT PHYSICAL EXAMINATION OR

9 AUTOPSY

10 Sec. 1251.116. LEGAL OR EQUITABLE ACTIONS; LIMITATIONS

11 Sec. 1251.117. CONTINUATION OR CONVERSION OF COVERAGE

12 [Sections 1251.118-1251.150 reserved for expansion]

13 SUBCHAPTER D. GROUP ACCIDENT AND HEALTH INSURANCE:

14 COVERAGE FOR DEPENDENTS

15 Sec. 1251.151. COVERAGE FOR CERTAIN GRANDCHILDREN

16 Sec. 1251.152. OPTIONAL COVERAGE FOR SPOUSES AND

17 DEPENDENTS

18 Sec. 1251.153. OPTIONAL CONTINUATION OF DEPENDENTS'

19 BENEFITS ON DEATH OF INSURED

20 Sec. 1251.154. COVERAGE FOR ADOPTED CHILDREN

21 [Sections 1251.155-1251.200 reserved for expansion]

22 SUBCHAPTER E. GROUP ACCIDENT AND HEALTH

23 INSURANCE: GENERAL PROVISIONS

24 Sec. 1251.201. CERTIFICATE OF INSURANCE

25 [Sections 1251.202-1251.250 reserved for expansion]

26 SUBCHAPTER F. CONTINUATION OR CONVERSION PRIVILEGE ON

27 TERMINATION OF COVERAGE UNDER GROUP POLICY

- 1 Sec. 1251.251. CONTINUATION OF GROUP COVERAGE REQUIRED;
2 EXCEPTION
3 Sec. 1251.252. ELIGIBILITY FOR CONTINUATION OF GROUP
4 COVERAGE
5 Sec. 1251.253. REQUEST FOR CONTINUATION OF GROUP COVERAGE
6 Sec. 1251.254. PAYMENT OF CONTRIBUTIONS
7 Sec. 1251.255. TERMINATION OF CONTINUED COVERAGE
8 Sec. 1251.256. CONVERSION OF GROUP POLICY
9 Sec. 1251.257. PREMIUM FOR CONVERTED POLICY
10 Sec. 1251.258. BENEFITS UNDER CONVERTED POLICY
11 Sec. 1251.259. TERMINATION OF CONVERTED POLICY
12 Sec. 1251.260. NOTICE OF CONTINUATION AND CONVERSION
13 PRIVILEGES
14 [Sections 1251.261-1251.300 reserved for expansion]
15 SUBCHAPTER G. CONTINUATION OF GROUP COVERAGE FOR CERTAIN
16 FAMILY MEMBERS AND DEPENDENTS
17 Sec. 1251.301. CONTINUATION OF GROUP COVERAGE
18 Sec. 1251.302. ELIGIBILITY FOR CONTINUED COVERAGE
19 Sec. 1251.303. PHYSICAL EXAMINATION NOT REQUIRED
20 Sec. 1251.304. SCOPE OF COVERAGE
21 Sec. 1251.305. AMOUNT OF PREMIUM
22 Sec. 1251.306. PAYMENT OF PREMIUMS
23 Sec. 1251.307. NOTICE OF CONTINUATION OPTION
24 Sec. 1251.308. NOTICE OF SEVERANCE OF FAMILY RELATIONSHIP;
25 NOTICE OF DESIRE TO EXERCISE OPTION
26 Sec. 1251.309. CONTINUATION OF CERTAIN COVERAGES
27 Sec. 1251.310. TERMINATION OF CONTINUED COVERAGE

[Sections 1251.311-1251.350 reserved for expansion]

SUBCHAPTER H. BLANKET ACCIDENT AND HEALTH INSURANCE:

ELIGIBLE POLICYHOLDERS

Sec. 1251.351. COMMON CARRIER OR MOTOR VEHICLE RENTAL OR
LEASING COMPANY

Sec. 1251.352. EMPLOYERS

Sec. 1251.353. EDUCATIONAL INSTITUTIONS

Sec. 1251.354. RELIGIOUS, CHARITABLE, RECREATIONAL,
EDUCATIONAL, OR CIVIC ORGANIZATION

Sec. 1251.355. SPORTS TEAM OR CAMP

Sec. 1251.356. GOVERNMENTAL OR VOLUNTEER EMERGENCY
SERVICES ORGANIZATION

Sec. 1251.357. NEWSPAPER OR OTHER PUBLISHER

Sec. 1251.358. ASSOCIATION

Sec. 1251.359. COVERAGE FOR OTHER RISKS

[Sections 1251.360-1251.400 reserved for expansion]

SUBCHAPTER I. BLANKET ACCIDENT AND HEALTH INSURANCE:

GENERAL PROVISIONS

Sec. 1251.401. INDIVIDUAL APPLICATION AND CERTIFICATE
NOT REQUIRED

Sec. 1251.402. LIABILITY OF POLICYHOLDER NOT AFFECTED

[Sections 1251.403-1251.450 reserved for expansion]

SUBCHAPTER J. REGULATION OF OUT-OF-STATE GROUP

ACCIDENT AND HEALTH INSURANCE COVERAGE

Sec. 1251.451. APPLICABILITY OF CERTAIN LAWS TO OUT-OF-STATE
GROUP ACCIDENT AND HEALTH INSURANCE
COVERAGE

CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1251.001. DEFINITIONS. In this chapter:

(1) "Blanket accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter H.

(2) "Group accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter B.

(3) "Group hospital service corporation" means a corporation operating under Chapter 842. (V.T.I.C. Art. 3.51-6, Secs. 1(a) (part), 2(a) (part).)

Sec. 1251.002. CERTAIN GROUP HEALTH INSURANCE AUTHORIZED. A group policy of accident, health, or accident and health insurance, including a group contract issued by a group hospital service corporation, may be delivered or issued for delivery in this state only if the policy:

(1) covers a group described by Subchapter B; and

(2) meets the requirements adopted under this chapter for a group policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(1).)

Sec. 1251.003. CERTAIN BLANKET HEALTH INSURANCE AUTHORIZED. A blanket policy of accident, health, or accident and health insurance may be delivered or issued for delivery in this state only if the policy:

(1) covers a group described by Subchapter H; and

(2) meets the requirements adopted under this chapter for a blanket policy. (V.T.I.C. Art. 3.51-6, Sec. 2(d).)

Sec. 1251.004. CERTAIN PAYMENTS BY INSURERS PROHIBITED.

(a) Except as reimbursement for the cost of services that otherwise would have been provided by the insurer, an insurer may not pay to any individual, firm, corporation, or group entity a fee or allowance for services related to:

(1) a group accident and health insurance policy; or

(2) a blanket accident and health insurance policy.

(b) Subsection (a) does not limit an insurer's right to:

(1) pay dividends;

(2) return a premium to a group or a combination of groups;

(3) provide for a rate stabilization fund with combinations of groups; or

(4) pay compensation, including a commission, to a licensed agent. (V.T.I.C. Art. 3.51-6, Secs. 1(e), 2(e).)

Sec. 1251.005. PAYMENT OF BENEFITS. (a) Except as otherwise provided by this section or Section 1251.113, benefits under a group accident and health insurance policy or blanket accident and health insurance policy must be paid to:

(1) the insured;

(2) the insured's designated beneficiary;

(3) the insured's estate; or

(4) if the insured is a minor or is otherwise not competent to give a valid release, the insured's parent, guardian, or other person actually supporting the insured.

(b) A group accident and health insurance policy or blanket accident and health insurance policy may provide that all or a

1 portion of any indemnity provided by the policy because of
2 hospital, nursing, medical, or surgical services may, at the option
3 of the insurer and unless the insured requests otherwise in writing
4 not later than the time of filing a proof of the loss, be paid
5 directly to the hospital or person providing the services. A
6 payment made as provided by this subsection discharges the
7 obligation of the insurer with respect to the amount paid.

8 (c) A group accident and health insurance policy or blanket
9 accident and health insurance policy must provide that all or a
10 portion of any benefits provided by the policy for dental care
11 services may, at the option of the insured, be assigned to the
12 dentist providing the services. In the case of an assignment under
13 this subsection, payment must be made directly to the dentist
14 designated. A payment made pursuant to an assignment under this
15 subsection discharges the obligation of the insurer with respect to
16 the amount paid. (V.T.I.C. Art. 3.51-6, Sec. 3 (part).)

17 Sec. 1251.006. POLICY MAY NOT SPECIFY SERVICE PROVIDER. A
18 group accident and health insurance policy or blanket accident and
19 health insurance policy may not require that a covered service be
20 provided by a particular hospital or person. (V.T.I.C. Art.
21 3.51-6, Sec. 3 (part).)

22 Sec. 1251.007. EXCEPTIONS. This subchapter and Subchapters
23 B-I do not apply to:

24 (1) a credit accident and health insurance policy
25 subject to Chapter 1153;

26 (2) any group specifically provided for or authorized
27 by law in existence and covered under a policy filed with the State

Board of Insurance before April 1, 1975;

(3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Sec. 1251.008. RULES. The commissioner may adopt rules necessary to administer this chapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

[Sections 1251.009-1251.050 reserved for expansion]

SUBCHAPTER B. GROUP ACCIDENT AND HEALTH INSURANCE:

ELIGIBLE POLICYHOLDERS

Sec. 1251.051. EMPLOYERS. (a) For purposes of this section, "employee" includes:

(1) an officer, manager, or employee of the employer;

(2) an individual proprietor or partner, if the employer is an individual proprietorship or partnership;

(3) an officer, manager, or employee of a subsidiary or affiliated corporation; and

1 (4) an individual proprietor, partner, or employee of
2 an individual or firm, if the business of the employer and the
3 individual or firm is under common control through stock ownership,
4 contract, or otherwise.

5 (b) A policy issued to insure employees of a public body may
6 provide that the term "employee" includes an elected or appointed
7 officer of the body.

8 (c) A policy issued to the trustees of a fund established by
9 an employer may provide that the term "employee" includes a
10 trustee, an employee of the trustees, or both, if the person's
11 duties are principally connected with the trusteeship.

12 (d) A group accident and health insurance policy may be
13 issued to an employer or trustees of a fund established by an
14 employer to insure the employer's active and retired employees for
15 the benefit of persons other than the employer.

16 (e) The employer or the trustees of a fund established by an
17 employer are the policyholder under a policy to which this section
18 applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

19 Sec. 1251.052. ASSOCIATIONS. (a) A group accident and
20 health insurance policy may be issued to an association, including
21 a labor union or an organization of labor unions, a membership
22 corporation organized or holding a certificate of authority under
23 the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq.,
24 Vernon's Texas Civil Statutes), and a cooperative or corporation
25 subject to the supervision and control of the Farm Credit
26 Administration, to insure the association's active and retired
27 members, employees, or employees of members for the benefit of

1 persons other than the association or its officers or trustees.

2 (b) To be eligible to obtain a group accident and health
3 insurance policy, an association must:

4 (1) have a constitution and bylaws;

5 (2) have been organized and have actively existed for
6 at least two years; and

7 (3) be maintained in good faith for purposes other
8 than that of obtaining insurance. (V.T.I.C. Art. 3.51-6, Sec. 1(a)
9 (part).)

10 Sec. 1251.053. FUNDS ESTABLISHED BY EMPLOYERS, LABOR
11 UNIONS, OR ASSOCIATIONS. (a) A group accident and health insurance
12 policy may be issued to the trustees of a fund established by two or
13 more employers in the same or related industry, by one or more labor
14 unions, by one or more employers and one or more labor unions, or by
15 an association described by Section 1251.052 to insure the active
16 and retired employees of the employers, members of the union or
17 association, or employees of the association for the benefit of
18 persons other than the employers, union, or association.

19 (b) A policy issued to the trustees of a fund established by
20 employers or a labor union or association may provide that the term
21 "employee" includes:

22 (1) an officer or manager of the employer;

23 (2) an individual proprietor or partner, if the
24 employer is an individual proprietorship or partnership; or

25 (3) a trustee, an employee of the trustees, or both, if
26 the person's duties are principally connected with the trusteeship.

27 (c) The trustees of a fund established by employers or a

1 labor union or association are the policyholder under a policy to
2 which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a)
3 (part).)

4 Sec. 1251.054. ELIGIBILITY FOR GROUP LIFE INSURANCE. A
5 group accident and health insurance policy may be issued to any
6 individual or organization to which a policy of group life
7 insurance may be issued or delivered in this state to insure any
8 class or classes of individuals that could be insured under the
9 group life policy. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

10 Sec. 1251.055. FUND FOR FORMER EMPLOYEES AND MEMBERS. (a)
11 An insurer may issue a group accident and health insurance policy
12 to a trustee of a fund to insure former employees, former members,
13 and the spouses, former spouses, and dependents of former employees
14 and members who were previously insured by the insurer under a
15 policy issued to any entity described by this subchapter.

16 (b) The trustee of a fund is the policyholder under a policy
17 to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a)
18 (part).)

19 Sec. 1251.056. OTHER GROUPS. (a) Under the requirements
20 prescribed by this section, a group accident and health insurance
21 policy may be issued to cover a group other than a group described
22 by Sections 1251.051-1251.055 if the commissioner determines that:

23 (1) the issuance of the policy is not contrary to the
24 best interest of the public;

25 (2) the issuance of the policy would result in
26 economies of acquisition or administration; and

27 (3) the benefits are reasonable in relation to the

1 premiums charged.

2 (b) Group accident and health insurance coverage may not be
3 offered to a group in this state by an insurer under a policy issued
4 in another state unless this state or another state having
5 requirements substantially similar to those prescribed by
6 Subsections (a)(1)-(3) has determined that those requirements have
7 been met.

8 (c) The premium for the policy must be paid from the
9 policyholder's funds, funds contributed by the covered persons, or
10 both. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

11 [Sections 1251.057-1251.100 reserved for expansion]

12 SUBCHAPTER C. GROUP ACCIDENT AND HEALTH INSURANCE:

13 REQUIRED PROVISIONS

14 Sec. 1251.101. REQUIRED PROVISIONS. (a) A group accident
15 and health insurance policy, including a group contract issued by a
16 group hospital service corporation, may not be delivered in this
17 state unless the policy contains in substance the provisions
18 prescribed by this subchapter or provisions in relation to
19 provisions prescribed by this subchapter that, in the opinion of
20 the commissioner, are:

21 (1) more favorable to the insureds under the policy;
22 or

23 (2) at least as favorable to the insureds under the
24 policy and more favorable to the policyholder.

25 (b) The standard provisions required for individual health
26 insurance policies do not apply to group health insurance policies.

27 (c) If any provision of this subchapter is wholly or partly

1 inapplicable to or inconsistent with the coverage provided by a
2 particular form of policy, the insurer, with the approval of the
3 commissioner, shall:

4 (1) omit the inapplicable provision or part from the
5 policy; or

6 (2) modify the inconsistent provision in a manner that
7 makes the provision as contained in the policy consistent with the
8 coverage provided by the policy. (V.T.I.C. Art. 3.51-6, Sec.
9 1(d)(2) (part).)

10 Sec. 1251.102. PAYMENT OF PREMIUMS. A group accident and
11 health insurance policy must provide that premiums due under the
12 policy must be remitted by the premium payor as designated in the
13 policy:

14 (1) on or before the due date; or

15 (2) within any grace period specified in the policy.
16 (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

17 Sec. 1251.103. INCONTESTABILITY OF POLICY. (a) A group
18 accident and health insurance policy must provide that:

19 (1) the validity of the policy may not be contested
20 after the policy has been in force for two years after its date of
21 issue; and

22 (2) in the absence of fraud, a statement made by any
23 individual covered by the policy relating to the individual's
24 insurability may not be used in contesting the validity of the
25 insurance with respect to which the statement was made:

26 (A) after the insurance has been in force before
27 the contest for two years during the individual's lifetime; and

1 (B) unless the statement is contained in a
2 written instrument signed by the individual making the statement.

3 (b) Subsection (a)(1) does not apply to a contest based on
4 nonpayment of premiums.

5 (c) The provisions required by this section do not preclude
6 the assertion at any time of a defense based on:

7 (1) a provision in the policy that relates to
8 eligibility for coverage;

9 (2) a provision in a group accident and health
10 insurance policy or disability insurance policy that relates to
11 overinsurance;

12 (3) a provision in a disability policy that relates to
13 the relation of earnings to insurance; or

14 (4) another similar provision in a group accident and
15 health insurance policy or disability insurance policy that limits
16 the amounts of recovery from all sources to not more than 100
17 percent of the total actual losses or expenses incurred. (V.T.I.C.
18 Art. 3.51-6, Sec. 1(d)(2) (part).)

19 Sec. 1251.104. ENTIRE CONTRACT. A group accident and
20 health insurance policy must provide that the policy and any
21 application attached to the policy constitute the entire contract
22 between the parties. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

23 Sec. 1251.105. STATEMENT MADE BY POLICYHOLDER OR INSURED.
24 A group accident and health insurance policy must provide that:

25 (1) in the absence of fraud, a statement made by the
26 policyholder or an insured is considered a representation and not a
27 warranty; and

1 (2) a statement made by the policyholder or an insured
2 may not be used in any contest under the policy, unless a copy of the
3 written instrument containing the statement is or has been provided
4 to:

5 (A) the person making the statement; or

6 (B) if the statement was made by the insured and
7 the insured has died or become incapacitated, the insured's
8 beneficiary or personal representative. (V.T.I.C. Art. 3.51-6,
9 Sec. 1(d)(2) (part).)

10 Sec. 1251.106. DISTINCTION BASED ON MARITAL STATUS
11 PROHIBITED. A group accident and health insurance policy must
12 include a provision that prohibits a distinction on the basis of the
13 marital status or lack of marital status between an insured and the
14 other parent in the determination of the dependents or the
15 beneficiaries of the insured, or both. (V.T.I.C. Art. 3.51-6, Sec.
16 1(d)(2) (part).)

17 Sec. 1251.107. EVIDENCE OF INSURABILITY. A group accident
18 and health insurance policy must state the conditions, if any,
19 under which the insurer reserves the right to require an individual
20 eligible for insurance to provide evidence of individual
21 insurability satisfactory to the insurer as a condition of
22 obtaining part or all of the coverage. (V.T.I.C. Art. 3.51-6, Sec.
23 1(d)(2) (part).)

24 Sec. 1251.108. EXCLUSION OR LIMITATION OF COVERAGE FOR
25 PREEXISTING CONDITIONS. (a) A group accident and health insurance
26 policy must specify the additional exclusions or limitations, if
27 any, applicable under the policy with respect to a disease or

1 physical condition of an insured, not otherwise excluded from the
2 insured's coverage by name or specific description effective on the
3 date of the insured's loss, that existed before the effective date
4 of the insured's coverage under the policy.

5 (b) An exclusion or limitation described by Subsection (a)
6 may apply only to a disease or physical condition for which the
7 insured received medical advice or treatment during the 12 months
8 before the effective date of the insured's coverage.

9 (c) An exclusion or limitation described by Subsection (a)
10 may not apply to a loss incurred or disability beginning after the
11 earlier of:

12 (1) the end of 12 consecutive months, beginning on or
13 after the effective date of the insured's coverage, during which
14 the insured has not received medical advice or treatment in
15 connection with the disease or physical condition; or

16 (2) the second anniversary of the effective date of
17 the insured's coverage.

18 (d) This section does not apply to:

19 (1) a credit accident and health insurance policy; or

20 (2) a group accident and health insurance policy
21 subject to Chapter 1501. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2)
22 (part).)

23 Sec. 1251.109. ADJUSTMENT OF PREMIUMS OR BENEFITS IF AGE OF
24 INSURED IS MISSTATED. (a) A group accident and health insurance
25 policy under which the premiums or benefits vary by age must specify
26 an equitable adjustment of premiums or benefits, or both, to be made
27 if the age of an insured has been misstated.

1 (b) The provision required by Subsection (a) must contain a
2 clear statement of the method of adjustment to be used. (V.T.I.C.
3 Art. 3.51-6, Sec. 1(d)(2) (part).)

4 Sec. 1251.110. DEADLINE FOR NOTICE OF CLAIM. (a) A group
5 accident and health insurance policy must provide that written
6 notice of a claim must be given to the insurer not later than the
7 20th day after the date of the occurrence or beginning of any loss
8 covered by the policy.

9 (b) Failure to give notice within the time prescribed by
10 Subsection (a) does not invalidate or reduce any claim if it is
11 shown that:

12 (1) it was not reasonably possible to give the notice
13 within that time; and

14 (2) notice was given as soon as was reasonably
15 possible. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

16 Sec. 1251.111. CLAIM FORMS. (a) A group accident and
17 health insurance policy must provide that the insurer will furnish
18 to the person making a claim or to the policyholder for delivery to
19 a person making a claim the forms usually provided by the insurer
20 for filing a proof of loss.

21 (b) If the forms for a proof of loss are not provided before
22 the 16th day after the date the insurer received notice of a claim
23 under the policy, the person making the claim is considered to have
24 complied with the requirements of the policy as to proof of loss on
25 submitting, within the time set in the policy for filing proof of
26 loss, written proof covering the occurrence, character, and extent
27 of the loss for which the claim is made. (V.T.I.C. Art. 3.51-6,

1 Sec. 1(d)(2) (part).)

2 Sec. 1251.112. DEADLINE FOR CLAIM. (a) A group accident
3 and health insurance policy must provide that:

4 (1) in the case of a claim for a loss other than a claim
5 for a loss of time for disability, written proof of the loss must be
6 provided to the insurer not later than the 90th day after the date
7 of the loss; and

8 (2) in the case of a claim for loss of time for
9 disability:

10 (A) written proof of the loss must be provided to
11 the insurer not later than the 90th day after the beginning of the
12 period for which the insurer is liable; and

13 (B) subsequent written proofs of the continuance
14 of the disability must be provided to the insurer at intervals as
15 reasonably required by the insurer.

16 (b) Failure to provide written proof of a loss within the
17 time prescribed by Subsection (a) does not invalidate or reduce a
18 claim if:

19 (1) it was not reasonably possible to provide written
20 proof of the loss within that time;

21 (2) written proof of the loss is provided as soon as
22 reasonably possible; and

23 (3) unless the claimant does not have the legal
24 capacity to provide proof of loss, proof of loss is provided not
25 later than the first anniversary of the date the proof of loss is
26 otherwise required. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

27 Sec. 1251.113. PROMPT PAYMENT OF BENEFITS REQUIRED. A

1 group accident and health insurance policy must provide that:

2 (1) all benefits payable under the policy, other than
3 benefits for loss of time, must be paid not later than the 60th day
4 after the date the proof of loss is received; and

5 (2) subject to written proof of loss, all accrued
6 benefits payable under the policy for loss of time must be paid at
7 least monthly during the period for which the insurer is liable, and
8 that any balance remaining unpaid at the end of that period must be
9 paid as soon as possible after the proof of loss is received.
10 (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

11 Sec. 1251.114. PAYMENT OF BENEFITS. (a) A group accident
12 and health insurance policy must provide that all benefits of the
13 policy, other than benefits for loss of life, must be paid to the
14 insured or the insured's assignee.

15 (b) A group accident and health insurance policy must
16 provide that, subject to the provisions of the policy, benefits for
17 loss of life of an insured must be paid to:

18 (1) the beneficiary designated by the insured or the
19 beneficiary's assignee;

20 (2) the family member specified by the policy terms,
21 if the policy contains conditions relating to family status; or

22 (3) the estate of the insured, if the designated or
23 specified beneficiary is not living at the time the insured dies.

24 (c) A group accident and health insurance policy may provide
25 that if any benefits are payable to the estate of an individual or
26 to an individual who is a minor or is otherwise not competent to
27 give a valid release, the insurer may pay the benefits, up to an

1 amount established by the commissioner, to any individual related
2 by consanguinity or affinity to the individual who is considered by
3 the insurer to be equitably entitled to the benefits.

4 (d) This section does not apply to:

5 (1) a credit accident and health insurance policy; or

6 (2) a group contract issued by a group hospital
7 service corporation. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

8 Sec. 1251.115. RIGHT TO CONDUCT PHYSICAL EXAMINATION OR
9 AUTOPSY. A group accident and health insurance policy must provide
10 that the insurer has the right and opportunity to:

11 (1) conduct a physical examination of an individual
12 for whom a claim is made when and as often as the insurer reasonably
13 requires during the pendency of the claim under the policy; and

14 (2) in the case of a death, require that an autopsy be
15 conducted, unless the autopsy is prohibited by law. (V.T.I.C. Art.
16 3.51-6, Sec. 1(d)(2) (part).)

17 Sec. 1251.116. LEGAL OR EQUITABLE ACTIONS; LIMITATIONS. A
18 group accident and health insurance policy must provide that an
19 action at law or in equity may not be brought to recover on the
20 policy:

21 (1) before the 61st day after the date written proof of
22 loss is filed as required under the policy; or

23 (2) after the third anniversary of the date on which
24 written proof of loss is required under the policy to be filed.
25 (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

26 Sec. 1251.117. CONTINUATION OR CONVERSION OF COVERAGE. (a)
27 A group accident and health insurance policy must describe the

1 continuation of group coverage and any conversion coverage provided
2 in accordance with Subchapter F.

3 (b) Subsection (a) does not apply to a credit accident and
4 health insurance policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2)
5 (part).)

6 [Sections 1251.118-1251.150 reserved for expansion]

7 SUBCHAPTER D. GROUP ACCIDENT AND HEALTH INSURANCE:

8 COVERAGE FOR DEPENDENTS

9 Sec. 1251.151. COVERAGE FOR CERTAIN GRANDCHILDREN. (a) A
10 group policy or contract of insurance for hospital, surgical, or
11 medical expenses incurred as a result of accident or sickness,
12 including a group contract issued by a group hospital service
13 corporation, that provides coverage under the policy or contract
14 for a child of an insured must, on payment of a premium, provide
15 coverage for any grandchild of the insured if the grandchild is:

16 (1) unmarried;

17 (2) younger than 25 years of age; and

18 (3) a dependent of the insured for federal income tax
19 purposes at the time the application for coverage of the grandchild
20 is made.

21 (b) Coverage for a grandchild of the insured under this
22 section may not be terminated solely because the covered grandchild
23 is no longer a dependent of the insured for federal income tax
24 purposes. (V.T.I.C. Art. 3.51-6, Sec. 3E, as amended Acts 77th
25 Leg., R.S., Chs. 396 and 1027.)

26 Sec. 1251.152. OPTIONAL COVERAGE FOR SPOUSES AND
27 DEPENDENTS. (a) For purposes of this section, "dependent"

1 includes:

2 (1) a child of an employee or member who is:

3 (A) unmarried; and

4 (B) younger than 25 years of age; and

5 (2) a grandchild of an employee or member who is:

6 (A) unmarried;

7 (B) younger than 25 years of age; and

8 (C) a dependent of the insured for federal income
9 tax purposes at the time the application for coverage of the
10 grandchild is made.

11 (b) A group accident and health insurance policy may provide
12 coverage for the spouse or a dependent of an employee or member.
13 (V.T.I.C. Art. 3.51-6, Sec. 1(b), as amended Acts 77th Leg., R.S.,
14 Chs. 396 and 1027.)

15 Sec. 1251.153. OPTIONAL CONTINUATION OF DEPENDENTS'
16 BENEFITS ON DEATH OF INSURED. (a) A group accident and health
17 insurance policy that provides for the payment by the insurer of
18 benefits for members of the family or dependents of an insured may
19 provide for a continuation of all or part of those benefits after
20 the death of the insured.

21 (b) Insurance provided by benefits described by Subsection
22 (a) is not life insurance under Title 7.

23 (c) Coverage described by Subsection (a) may continue for
24 any period subject to any other policy provisions relating to the
25 termination of a dependent's coverage. (V.T.I.C. Art. 3.51-6, Sec.
26 1(f).)

27 Sec. 1251.154. COVERAGE FOR ADOPTED CHILDREN. A group

1 policy or contract of insurance for hospital, surgical, or medical
2 expenses incurred as a result of accident or sickness, including a
3 group contract issued by a group hospital service corporation, that
4 provides coverage for the immediate family or a child of an insured
5 may not exclude from coverage or limit coverage of a child of the
6 insured solely because the child is adopted. A child is considered
7 to be the child of an insured if the insured is a party to a suit in
8 which the insured seeks to adopt the child. (V.T.I.C. Art. 3.51-6,
9 Sec. 3D.)

10 [Sections 1251.155-1251.200 reserved for expansion]

11 SUBCHAPTER E. GROUP ACCIDENT AND HEALTH

12 INSURANCE: GENERAL PROVISIONS

13 Sec. 1251.201. CERTIFICATE OF INSURANCE. (a) An insurer
14 issuing a group policy under this chapter shall provide to the
15 policyholder for delivery to each employee or member of the insured
16 group a certificate of insurance that:

17 (1) summarizes the essential features of the insurance
18 coverage of the employee or member; and

19 (2) states the person to whom benefits are payable.

20 (b) If dependents are included in the coverage, an insurer
21 is not required to provide more than one certificate for each family
22 unit. (V.T.I.C. Art. 3.51-6, Sec. 1(c).)

23 [Sections 1251.202-1251.250 reserved for expansion]

24 SUBCHAPTER F. CONTINUATION OR CONVERSION PRIVILEGE ON

25 TERMINATION OF COVERAGE UNDER GROUP POLICY

26 Sec. 1251.251. CONTINUATION OF GROUP COVERAGE REQUIRED;
27 EXCEPTION. (a) An insurer or group hospital service corporation

1 that issues policies that provide hospital, surgical, or major
2 medical expense insurance coverage or any combination of those
3 coverages on an expense incurred basis shall, as required by this
4 subchapter, provide continuation of group coverage for employees or
5 members and their eligible dependents, subject to the eligibility
6 provisions prescribed by Section 1251.252.

7 (b) This subchapter does not apply to an insurance policy
8 that provides benefits only for expenses incurred because of a
9 specified disease or an accident. (V.T.I.C. Art. 3.51-6, Secs.
10 1(d)(3) (part), (3)(A)(i).)

11 Sec. 1251.252. ELIGIBILITY FOR CONTINUATION OF GROUP
12 COVERAGE. (a) An employee, member, or dependent is entitled to
13 continuation of group coverage if:

14 (1) the individual's coverage under the group policy
15 is terminated for any reason other than involuntary termination for
16 cause, including discontinuance of the group policy in its entirety
17 or with respect to an insured class; and

18 (2) the individual has been continuously insured under
19 the group policy, or under any group policy providing similar
20 benefits that the policy replaces, for at least three consecutive
21 months immediately before termination.

22 (b) For purposes of Subsection (a), involuntary termination
23 for cause does not include termination for any health-related
24 cause. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

25 Sec. 1251.253. REQUEST FOR CONTINUATION OF GROUP COVERAGE.
26 An employee, member, or dependent must request in writing the
27 continuation of group coverage not later than the 31st day after the

1 later of:

2 (1) the date the group coverage would otherwise
3 terminate; or

4 (2) the date the individual is given, in a format
5 prescribed by the commissioner, notice by either the employer or
6 the group policyholder of the right to continuation of group
7 coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(A)(ii).)

8 Sec. 1251.254. PAYMENT OF CONTRIBUTIONS. (a) An employee,
9 member, or dependent who elects to continue group coverage under
10 this subchapter must pay to the employer or group policyholder,
11 each month in advance, the amount of contribution required by the
12 employer or policyholder, plus two percent of the group rate for the
13 coverage being continued under the group policy on the due date of
14 each payment.

15 (b) The employee's, member's, or dependent's written
16 election for continuation of group coverage, together with the
17 first contribution required to establish advance monthly
18 contributions, must be given to the employer or policyholder not
19 later than the later of:

20 (1) the 31st day after the date coverage would
21 otherwise terminate; or

22 (2) the date the individual is given notice by either
23 the employer or the group policyholder of the right to continuation
24 of group coverage. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(iii),
25 (iv).)

26 Sec. 1251.255. TERMINATION OF CONTINUED COVERAGE. (a)
27 Group coverage continued under this subchapter may not terminate

1 until the earliest of:

2 (1) six months after the date the employee, member, or
3 dependent elects to continue the group coverage;

4 (2) the date failure to make timely payments would
5 terminate the group coverage;

6 (3) the date the group coverage terminates in its
7 entirety;

8 (4) the date the insured is or could be covered under
9 Medicare;

10 (5) the date the insured is covered for similar
11 benefits by another plan or program, including:

12 (A) a hospital, surgical, medical, or major
13 medical expense insurance policy;

14 (B) a hospital or medical service subscriber
15 contract; or

16 (C) a medical practice or other prepayment plan;

17 (6) the date the insured is eligible for similar
18 benefits, whether or not covered for those benefits, under any
19 arrangement of coverage for individuals in a group, whether on an
20 insured or uninsured basis; or

21 (7) the date similar benefits are provided or
22 available to the insured under any state or federal law.

23 (b) Not later than the 30th day before the end of the six
24 months after the date the employee, member, or dependent elects to
25 continue group coverage under the policy, the insurer shall:

26 (1) notify the individual that the individual may be
27 eligible for coverage under the Texas Health Insurance Risk Pool as

1 provided by Chapter 1506; and

2 (2) provide to the individual the address for applying
3 to that pool. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(v), (vi).)

4 Sec. 1251.256. CONVERSION OF GROUP POLICY. (a) An insurer
5 may offer a conversion policy to each employee, member, or
6 dependent who is covered under a group accident and health
7 insurance policy that is terminating.

8 (b) If offered, an issuer shall issue a conversion policy
9 without evidence of insurability if a written application for the
10 policy and payment of the first premium are made not later than the
11 31st day after the date of termination.

12 (c) Any conversion policy must meet the minimum standards
13 for benefits for conversion policies.

14 (d) The insurer may provide the conversion coverage on an
15 individual or group basis. (V.T.I.C. Art. 3.51-6, Secs.
16 1(d)(3)(B)(i), (iii).)

17 Sec. 1251.257. PREMIUM FOR CONVERTED POLICY. (a) An
18 insurer shall determine the premium for a converted policy issued
19 under this subchapter in accordance with the insurer's table of
20 premium rates for coverage that was provided under the group
21 policy. The premium:

22 (1) must be based on the type of converted policy and
23 the coverage provided by the policy; and

24 (2) may be based on the age and geographic location of
25 each individual to be covered.

26 (b) The premium for the same coverage and benefits under a
27 converted policy may not exceed 200 percent of the premium

determined for the group policy in accordance with Subsection (a).
(V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

Sec. 1251.258. BENEFITS UNDER CONVERTED POLICY. The
commissioner by rule shall establish minimum standards for benefits
under converted policies issued under this subchapter. (V.T.I.C.
Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

Sec. 1251.259. TERMINATION OF CONVERTED POLICY. Conversion
coverage under this subchapter for an insured may not terminate
until the earlier of:

(1) the date failure to make timely payments would
terminate coverage; or

(2) the date of an event specified by Section
1251.255(a)(4), (5), (6), or (7) for termination of continued group
coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

Sec. 1251.260. NOTICE OF CONTINUATION AND CONVERSION
PRIVILEGES. (a) An employer that provides to its employees group
accident and health insurance coverage that includes a group
continuation or conversion privilege on termination of coverage
shall give written notice of the continuation or conversion
privileges under the policy to each employee or dependent insured
under the group and affected by the termination.

(b) The commissioner by rule shall establish minimum
standards for the notice required by this section. (V.T.I.C. Art.
3.51-6, Sec. 3C, as added Acts 71st Leg., R.S., Ch. 1041, Sec. 10.)

[Sections 1251.261-1251.300 reserved for expansion]

SUBCHAPTER G. CONTINUATION OF GROUP COVERAGE FOR CERTAIN

FAMILY MEMBERS AND DEPENDENTS

1 Sec. 1251.301. CONTINUATION OF GROUP COVERAGE. A group
2 policy or contract delivered, issued for delivery, renewed,
3 amended, or extended in this state, including a group contract
4 issued by a group hospital service corporation, that provides
5 insurance for hospital, surgical, or medical expenses incurred as a
6 result of accident or sickness must include an option for each
7 individual covered by the policy or contract because of a family or
8 dependent relationship to an individual who is a member of the group
9 for which the policy or contract is provided to continue coverage
10 with the group if the individual's eligibility for coverage under
11 the policy or contract ends because of:

12 (1) the severance of the family relationship; or

13 (2) the retirement or death of the group member.

14 (V.T.I.C. Art. 3.51-6, Secs. 3B(a), (b) (part).)

15 Sec. 1251.302. ELIGIBILITY FOR CONTINUED COVERAGE. A
16 family member or dependent of an insured is eligible for continued
17 coverage under this subchapter if the family member or dependent:

18 (1) has been a member of the group for a period of at
19 least one year; or

20 (2) is an infant under one year of age. (V.T.I.C. Art.
21 3.51-6, Sec. 3B(b) (part).)

22 Sec. 1251.303. PHYSICAL EXAMINATION NOT REQUIRED. An
23 individual who exercises the option to continue group coverage
24 under this subchapter may not be required to take and pass a
25 physical examination as a condition to continuing coverage.
26 (V.T.I.C. Art. 3.51-6, Sec. 3B(c).)

27 Sec. 1251.304. SCOPE OF COVERAGE. (a) An individual

1 covered under group continuation coverage under this subchapter is
2 entitled to coverage that is identical in scope to the coverage
3 provided under the group health insurance policy or contract. An
4 exclusion that was not included in the health insurance policy or
5 contract may not be included in the group continuation coverage.

6 (b) If the group policyholder or contract holder replaces
7 the health insurance policy or contract within the period
8 prescribed by Section 1251.310(3), an individual covered under
9 group continuation coverage may obtain coverage identical in scope
10 to the coverage under the replacement group policy as provided by
11 this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 3B(d).)

12 Sec. 1251.305. AMOUNT OF PREMIUM. Except as provided by
13 Section 1551.064, the premium for continuation of a spouse or
14 dependent on the group health insurance policy or contract may not
15 be more than the premium charged under the group policy or contract
16 for the individual had the family relationship not been severed.
17 (V.T.I.C. Art. 3.51-6, Sec. 3B(f).)

18 Sec. 1251.306. PAYMENT OF PREMIUMS. (a) An individual
19 covered under group continuation coverage under this subchapter
20 shall pay premiums for the coverage directly to the group
21 policyholder or contract holder.

22 (b) The coverage must provide the individual with the option
23 of paying the premiums in monthly installments.

24 (c) The group policyholder or contract holder may require
25 the individual to pay a monthly fee of not more than \$5 for
26 administrative costs. (V.T.I.C. Art. 3.51-6, Sec. 3B(e).)

27 Sec. 1251.307. NOTICE OF CONTINUATION OPTION. Except as

1 provided by Section 1551.064, at the time a health insurance policy
2 or contract is issued, the group policyholder or contract holder
3 shall give written notice to each group member and each dependent of
4 a group member covered by the policy or contract of the continuation
5 option under this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 3B(g).)

6 Sec. 1251.308. NOTICE OF SEVERANCE OF FAMILY RELATIONSHIP;
7 NOTICE OF DESIRE TO EXERCISE OPTION. (a) Except as provided by
8 Section 1551.064, each group health insurance policy or contract
9 must require a group member to give written notice to the group
10 policyholder or contract holder not later than the 15th day after
11 the date of any severance of the family relationship that might
12 activate the continuation option under this subchapter. Written
13 notice under this subsection may be given by the group member's
14 dependent.

15 (b) On receipt of notice under Subsection (a), the group
16 policyholder or contract holder shall immediately give written
17 notice of the continuation option under this subchapter to each
18 affected dependent of the group member.

19 (c) On receipt of notice of the death or retirement of a
20 group member, the group policyholder or contract holder shall
21 immediately give written notice of the continuation option under
22 this subchapter to each dependent of the group member. The notice
23 must state the amount of the premium to be charged and must be
24 accompanied by any necessary enrollment forms.

25 (d) Not later than the 60th day after the date of the
26 severance of the family relationship or the retirement or death of
27 the group member, a dependent must give written notice to the group

1 policyholder or contract holder of the individual's desire to
2 exercise the continuation option under this subchapter. Coverage
3 under the health insurance policy or contract remains in effect
4 during the period prescribed by this subsection if the policy or
5 contract premiums are paid.

6 (e) If a dependent does not give written notice of the
7 individual's desire to exercise the continuation option under this
8 subchapter within the time prescribed by Subsection (d), the option
9 expires. (V.T.I.C. Art. 3.51-6, Secs. 3B(h), (i).)

10 Sec. 1251.309. CONTINUATION OF CERTAIN COVERAGES. (a) Any
11 period of previous coverage under the health insurance policy or
12 contract, including a policy or contract executed under Chapter
13 1551, must be used in full or partial satisfaction of any required
14 probationary or waiting periods provided in the contract for
15 dependent coverage.

16 (b) If a health insurance policy or contract provides to a
17 group member continuation rights to cover the period between the
18 time the member retires and the time the member is eligible for
19 coverage by Medicare, those same continuation rights must be made
20 available to the group member's dependents. (V.T.I.C. Art. 3.51-6,
21 Secs. 3B(j), (k).)

22 Sec. 1251.310. TERMINATION OF CONTINUED COVERAGE. The
23 coverage of an individual who exercises the continuation option
24 under this subchapter continues without interruption and may not be
25 canceled or otherwise terminated until:

26 (1) the insured fails to make a premium payment within
27 the time required to make the payment;

1 (2) the insured becomes eligible for substantially
2 similar coverage under another plan or program, including a group
3 health insurance policy or contract, hospital or medical service
4 subscriber contract, or medical practice or other prepayment plan;
5 or

6 (3) the third anniversary of:

7 (A) the severance of the family relationship; or

8 (B) the retirement or death of the group member.

9 (V.T.I.C. Art. 3.51-6, Sec. 3B(1).)

10 [Sections 1251.311-1251.350 reserved for expansion]

11 SUBCHAPTER H. BLANKET ACCIDENT AND HEALTH INSURANCE:

12 ELIGIBLE POLICYHOLDERS

13 Sec. 1251.351. COMMON CARRIER OR MOTOR VEHICLE RENTAL OR
14 LEASING COMPANY. (a) A blanket accident and health insurance
15 policy may be issued to:

16 (1) a common carrier or the operator, owner, or lessor
17 of a means of transportation to cover a group of individuals who may
18 become passengers defined by reference to their travel status on
19 the common carrier or means of transportation; or

20 (2) an automobile or truck rental or leasing company
21 to cover a group of individuals who may become renters, lessees, or
22 passengers defined by their travel status on the rented or leased
23 vehicles.

24 (b) The common carrier, the operator, owner, or lessor of a
25 means of transportation, or the automobile or truck rental or
26 leasing company is the policyholder under a policy to which this
27 section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

1 Sec. 1251.352. EMPLOYERS. (a) A blanket accident and
2 health insurance policy may be issued to an employer to cover any
3 group of employees, dependents, or guests defined by reference to
4 specified hazards incident to an activity or operation of the
5 employer.

6 (b) The employer is the policyholder under a policy to which
7 this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

8 Sec. 1251.353. EDUCATIONAL INSTITUTIONS. (a) A blanket
9 accident and health insurance policy may be issued to a college,
10 school, or other institution of learning, to a school district or
11 school jurisdictional unit, or to the head, principal, or governing
12 board of such an educational unit to cover students, teachers, or
13 employees.

14 (b) The institution, head, principal, or governing board is
15 the policyholder under a policy to which this section applies.
16 (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

17 Sec. 1251.354. RELIGIOUS, CHARITABLE, RECREATIONAL,
18 EDUCATIONAL, OR CIVIC ORGANIZATION. (a) A blanket accident and
19 health insurance policy may be issued to a religious, charitable,
20 recreational, educational, or civic organization, or a branch of
21 the organization, to cover any group of members or participants
22 defined by reference to specified hazards incident to an activity
23 or operation sponsored or supervised by the organization or branch.

24 (b) The organization or branch is the policyholder under a
25 policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec.
26 2(a) (part).)

27 Sec. 1251.355. SPORTS TEAM OR CAMP. (a) A blanket accident

1 and health insurance policy may be issued to a sports team or camp
2 or the sponsor of a sports team or camp to cover members, campers,
3 employees, officials, or supervisors.

4 (b) The sports team, camp, or sponsor is the policyholder
5 under a policy to which this section applies. (V.T.I.C. Art.
6 3.51-6, Sec. 2(a) (part).)

7 Sec. 1251.356. GOVERNMENTAL OR VOLUNTEER EMERGENCY
8 SERVICES ORGANIZATION. (a) A blanket accident and health
9 insurance policy may be issued to a governmental or volunteer fire
10 department or fire company, first aid or civil defense
11 organization, or similar governmental or volunteer organization to
12 cover a group of members or participants defined by reference to
13 specified hazards incident to an activity or operation sponsored or
14 supervised by the organization.

15 (b) The governmental or volunteer organization is the
16 policyholder under a policy to which this section applies.
17 (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

18 Sec. 1251.357. NEWSPAPER OR OTHER PUBLISHER. (a) A blanket
19 accident and health insurance policy may be issued to a newspaper or
20 other publisher to cover the publisher's carriers.

21 (b) The publisher is the policyholder under a policy to
22 which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a)
23 (part).)

24 Sec. 1251.358. ASSOCIATION. (a) A blanket accident and
25 health insurance policy may be issued to an association, including
26 a labor union, to cover any group of members or participants defined
27 by reference to specified hazards incident to an activity or

1 operation sponsored or supervised by the association.

2 (b) To be eligible to obtain a blanket accident and health
3 insurance policy, an association must:

4 (1) have a constitution and bylaws; and

5 (2) have been organized and be maintained in good
6 faith for purposes other than that of obtaining insurance.

7 (c) The association is the policyholder under a policy to
8 which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a)
9 (part).)

10 Sec. 1251.359. COVERAGE FOR OTHER RISKS. (a) A blanket
11 accident and health insurance policy may be issued to cover any risk
12 or class of risks other than a risk described by this subchapter
13 that, as determined by the commissioner, is eligible for blanket
14 accident and health insurance.

15 (b) The commissioner may make a determination under
16 Subsection (a) based on an individual risk, a class of risks, or
17 both. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

18 [Sections 1251.360-1251.400 reserved for expansion]

19 SUBCHAPTER I. BLANKET ACCIDENT AND HEALTH INSURANCE:

20 GENERAL PROVISIONS

21 Sec. 1251.401. INDIVIDUAL APPLICATION AND CERTIFICATE NOT
22 REQUIRED. (a) An individual application from an insured under a
23 blanket accident and health insurance policy is not required.

24 (b) An insurer is not required to provide a certificate to
25 each insured under a blanket accident and health insurance policy.
26 (V.T.I.C. Art. 3.51-6, Sec. 2(b).)

27 Sec. 1251.402. LIABILITY OF POLICYHOLDER NOT AFFECTED.

1 Subchapter H and this subchapter do not affect the legal liability
2 of a policyholder for the death of or injury to a member of a group.
3 (V.T.I.C. Art. 3.51-6, Sec. 2(c).)

4 [Sections 1251.403-1251.450 reserved for expansion]

5 SUBCHAPTER J. REGULATION OF OUT-OF-STATE GROUP

6 ACCIDENT AND HEALTH INSURANCE COVERAGE

7 Sec. 1251.451. APPLICABILITY OF CERTAIN LAWS TO
8 OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE. (a)
9 Chapters 1365 and 1368 and Subchapters A and C, Chapter 1451, apply
10 to:

11 (1) a certificate of insurance issued to a resident of
12 this state under a group accident and health insurance policy
13 delivered, issued for delivery, or renewed outside this state; or

14 (2) a certificate issued to a resident of this state
15 under a policy delivered, issued for delivery, or renewed outside
16 this state by a group hospital service corporation.

17 (b) Subsection (a) does not apply to a specified disease or
18 limited benefit policy. (V.T.I.C. Art. 3.51-12.)

19 CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP AND

20 GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

21 SUBCHAPTER A. GENERAL PROVISIONS

22 Sec. 1252.001. DEFINITIONS

23 Sec. 1252.002. APPLICABILITY OF CHAPTER

24 Sec. 1252.003. COVERAGE ISSUED ON GROUP-TYPE BASIS

25 [Sections 1252.004-1252.100 reserved for expansion]

26 SUBCHAPTER B. DISCONTINUATION OF COVERAGE

27 Sec. 1252.101. NOTICE OF DISCONTINUATION OF COVERAGE

1 Sec. 1252.102. EXTENSION OF BENEFITS PROVISION; EXEMPTION

2 Sec. 1252.103. INDEMNITY OR BENEFITS PAYABLE FOR
3 DISABILITY

4 Sec. 1252.104. LIABILITY FOR LOSS UNDER AUTOMATICALLY
5 DISCONTINUED COVERAGE

6 [Sections 1252.105-1252.200 reserved for expansion]

7 SUBCHAPTER C. REPLACEMENT OF COVERAGE

8 Sec. 1252.201. TOTAL DISABILITY STATUS

9 Sec. 1252.202. EFFECTIVE DATE OF COVERAGE UNDER
10 REPLACEMENT PLAN

11 Sec. 1252.203. EXTENSION OF BENEFITS FOR TOTAL DISABILITY

12 Sec. 1252.204. COVERAGE FOR PREEXISTING CONDITIONS

13 Sec. 1252.205. WAITING PERIOD

14 Sec. 1252.206. DETERMINATION OF BENEFITS AVAILABLE UNDER
15 REPLACED PLAN

16 Sec. 1252.207. LIABILITY OF PREVIOUS CARRIER

17 CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP AND
18 GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

19 SUBCHAPTER A. GENERAL PROVISIONS

20 Sec. 1252.001. DEFINITIONS. In this chapter:

21 (1) "Carrier" means:

22 (A) an insurer; or

23 (B) a group hospital service corporation
24 operating under Chapter 842.

25 (2) "Health benefit plan" means:

26 (A) any accident and health insurance policy;

27 (B) a subscriber contract of a group hospital

1 service corporation; or

2 (C) an accident and health benefits package of a
3 multiple employer trust that is not exempt from regulation by this
4 state as an employee welfare benefit plan under the Employee
5 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
6 seq.), as amended.

7 (3) "Previous carrier" means a carrier whose health
8 benefit plan coverage has been replaced with health benefit plan
9 coverage provided by a succeeding carrier.

10 (4) "Succeeding carrier" means a carrier that replaces
11 the health benefit plan coverage provided by another carrier with
12 its own health benefit plan coverage.

13 (5) "Total disability" or "totally disabled" means:

14 (A) with respect to an employee or other primary
15 insured covered under a health benefit plan, the complete inability
16 of that individual to perform all of the substantial and material
17 duties and functions of the individual's occupation and any other
18 gainful occupation in which the individual earns substantially the
19 same compensation earned before the disability; and

20 (B) with respect to any other individual covered
21 under a health benefit plan, confinement as a bed patient in a
22 hospital. (V.T.I.C. Art. 3.51-6A, Secs. 1 (part); 2(b); 5(f);
23 6(b)(1), (3); New.)

24 Sec. 1252.002. APPLICABILITY OF CHAPTER. (a) This chapter
25 applies only to a health benefit plan that:

26 (1) provides coverage on a group or group-type basis
27 to an individual eligible for that coverage because of the

individual's status as:

(A) an employee of an employer; or

(B) a member of a labor union or a member of an association; and

(2) is delivered or issued for delivery in this state.

(b) This chapter does not apply to an entity that is not engaged in the business of insurance in this state. (V.T.I.C. Art. 3.51-6A, Sec. 1.)

Sec. 1252.003. COVERAGE ISSUED ON GROUP-TYPE BASIS. (a) For purposes of this chapter, health benefit plan coverage is provided on a group-type basis if:

(1) the plan provides coverage under an insurance policy or subscriber contract to a class of employees or a class of members of a labor union or members of an association and the class is determined by conditions relating to their employment or to their membership in the union or association;

(2) coverage under the plan is not available to the general public and can be obtained and maintained only because of the covered individual's employment status or membership in a labor union or an association;

(3) premiums or subscription charges for the plan are paid to the carrier on an aggregate or bulk-payment basis; and

(4) the plan is sponsored by:

(A) the employer of the class of employees covered by the plan; or

(B) the labor union or an association to which the class of members covered by the plan belongs.

1 (b) Health benefit plan coverage is not provided on a
2 group-type basis if it is a salary-budget plan using individual
3 insurance policies or subscriber contracts that do not meet the
4 conditions for group-type coverage specified by Subsection (a).
5 (V.T.I.C. Art. 3.51-6A, Sec. 2(a).)

6 [Sections 1252.004-1252.100 reserved for expansion]

7 SUBCHAPTER B. DISCONTINUATION OF COVERAGE

8 Sec. 1252.101. NOTICE OF DISCONTINUATION OF COVERAGE. A
9 notice of discontinuation of a health benefit plan must include a
10 request to the group policyholder or other entity responsible for
11 making payments or submitting subscription charges to the carrier
12 to notify employees or members covered by the plan of the
13 discontinuation and the date of the discontinuation. (V.T.I.C.
14 Art. 3.51-6A, Sec. 4.)

15 Sec. 1252.102. EXTENSION OF BENEFITS PROVISION; EXEMPTION.

16 (a) A health benefit plan must contain, subject to this section and
17 Section 1252.103, a reasonable provision providing for an extension
18 of benefits for a total disability that exists on the date of the
19 plan's discontinuation.

20 (b) A health benefit plan must contain a reasonable
21 extension of benefits provision for coverage for hospital or
22 medical expenses other than dental expenses. A provision is
23 considered reasonable if it provides to an individual who is
24 covered under the plan and who is totally disabled on the date of
25 the plan's discontinuation an extension of benefits for expenses
26 incurred in treating the condition causing the total disability and
27 the extension is provided for at least the lesser of:

1 (1) 90 days; or

2 (2) the duration of the total disability.

3 (c) An extension of benefits provision required under this
4 section may provide for an exclusion from coverage for an
5 individual whose coverage is being discontinued and replaced with
6 coverage that:

7 (1) is provided by a succeeding carrier; and

8 (2) provides a level of benefits that is at least
9 substantially equal to the level of benefits provided under the
10 replaced health benefit plan.

11 (d) An applicable extension of benefits provision must be
12 described in the policy or contract and the group insurance
13 certificate.

14 (e) Benefits payable during an extension period may be
15 subject to the regular benefit limits of the health benefit plan.

16 (f) This section does not apply to a health benefit plan
17 that was delivered or issued for delivery in this state before
18 January 1, 1982, and whose level of benefits has not been modified
19 after December 31, 1981. (V.T.I.C. Art. 3.51-6A, Secs. 5(a), (c),
20 (d), (e).)

21 Sec. 1252.103. INDEMNITY OR BENEFITS PAYABLE FOR
22 DISABILITY. A discontinuation of health benefit plan coverage
23 occurring during a period of disability does not affect:

24 (1) any benefits payable under the plan for loss of
25 time from work because of the disability; or

26 (2) any specific indemnity required to be provided
27 under the plan during a period of hospital confinement. (V.T.I.C.

1 Art. 3.51-6A, Sec. 5(b).)

2 Sec. 1252.104. LIABILITY FOR LOSS UNDER AUTOMATICALLY
3 DISCONTINUED COVERAGE. (a) If a health benefit plan provides for
4 automatic discontinuation of coverage when a premium or
5 subscription charge due under the plan is not paid before the
6 expiration of a grace period specified in the plan for that payment,
7 the carrier or other entity responsible for making premium payments
8 or for submitting premiums or subscription charges to the carrier
9 is liable, on the submission of a valid claim, for a loss that is:

10 (1) covered by the plan; and

11 (2) incurred before the expiration of the grace
12 period.

13 (b) The commissioner may adopt reasonable rules necessary
14 to implement this section. (V.T.I.C. Art. 3.51-6A, Sec. 3.)

15 [Sections 1252.105-1252.200 reserved for expansion]

16 SUBCHAPTER C. REPLACEMENT OF COVERAGE

17 Sec. 1252.201. TOTAL DISABILITY STATUS. In this
18 subchapter, a reference to the total disability status of an
19 individual means the individual's disability status immediately
20 preceding the date on which the succeeding carrier's coverage takes
21 effect. (V.T.I.C. Art. 3.51-6A, Sec. 6(c).)

22 Sec. 1252.202. EFFECTIVE DATE OF COVERAGE UNDER REPLACEMENT
23 PLAN. (a) An individual who was covered by a previous carrier's
24 health benefit plan on the date on which that plan was discontinued
25 shall be provided coverage under the succeeding carrier's health
26 benefit plan as of the replacement plan's effective date if the
27 individual:

1 (1) is eligible for coverage because the individual is
2 a member of a class eligible for coverage under the replacement plan
3 and satisfies the replacement plan's actively at work and
4 nonconfinement requirements; and

5 (2) elects to be covered under the replacement plan.

6 (b) An individual who would be covered by the succeeding
7 carrier under Subsection (a) but who does not satisfy the
8 replacement plan's actively at work and nonconfinement
9 requirements shall be covered under the replacement plan when the
10 individual satisfies those requirements. (V.T.I.C. Art. 3.51-6A,
11 Sec. 6(e).)

12 Sec. 1252.203. EXTENSION OF BENEFITS FOR TOTAL DISABILITY.

13 (a) With respect to providing a type of coverage for which Section
14 1252.102 requires an extension of benefits for an individual with a
15 total disability, a succeeding carrier replacing a previous
16 carrier's plan that is not subject to that section must provide,
17 subject to Subsection (b), the lesser of:

18 (1) extended benefit coverage that the previous
19 carrier would have been required to provide under Section 1252.102
20 if the previous carrier had been subject to that section; or

21 (2) extended benefit coverage that the succeeding
22 carrier is required to provide under Section 1252.102.

23 (b) The extended benefit coverage may be reduced by any
24 benefits actually payable under the previous carrier's health
25 benefit plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(f).)

26 Sec. 1252.204. COVERAGE FOR PREEXISTING CONDITIONS. (a) A
27 succeeding carrier's health benefit plan that limits coverage in

1 accordance with a preexisting conditions provision, other than a
2 waiting period, must provide, during the period the limitation on
3 coverage is in effect, the level of benefits prescribed by this
4 section to an individual covered by the succeeding carrier who:

5 (1) has a preexisting condition; and

6 (2) was covered by the previous carrier's plan on the
7 date on which that plan was discontinued.

8 (b) The health benefit plan must provide a level of benefits
9 equal to the lesser of:

10 (1) the level of benefits available under the
11 succeeding carrier's plan as determined without applying the
12 preexisting conditions provision; or

13 (2) the level of benefits that would have been
14 available under the previous carrier's plan. (V.T.I.C. Art.
15 3.51-6A, Sec. 6(g).)

16 Sec. 1252.205. WAITING PERIOD. If the benefits that were
17 available under a previous carrier's health benefit plan are
18 similar to the benefits available under a succeeding carrier's
19 health benefit plan, the succeeding carrier shall give credit for
20 the satisfaction or partial satisfaction of any waiting period or
21 similar provision that has been satisfied under the previous
22 carrier's plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(h) (part).)

23 Sec. 1252.206. DETERMINATION OF BENEFITS AVAILABLE UNDER
24 REPLACED PLAN. (a) If a succeeding carrier requires a
25 determination of the benefits available under the previous
26 carrier's health benefit plan, the previous carrier shall provide
27 at the request of the succeeding carrier:

1 (1) a statement of the benefits available under the
2 previous carrier's plan; or

3 (2) pertinent information sufficient either to allow
4 verification of those benefits or to allow the succeeding carrier
5 to make a determination of those benefits.

6 (b) A determination of benefits under this section must be
7 made using the definitions of, and in accordance with all of the
8 conditions and covered expense provisions of, the previous
9 carrier's plan as if that plan had not been replaced. (V.T.I.C.
10 Art. 3.51-6A, Sec. 6(h) (part).)

11 Sec. 1252.207. LIABILITY OF PREVIOUS CARRIER. A carrier of
12 a health benefit plan that is being discontinued is liable only for
13 any accrued liabilities regarding the plan and for any extension of
14 benefits provided under the plan, regardless of whether the group
15 policyholder or any other entity responsible for making payments or
16 for submitting subscription charges to the carrier:

17 (1) replaces the coverage provided under the
18 discontinued plan with health benefit plan coverage provided by
19 another carrier;

20 (2) self-insures a health benefit plan; or

21 (3) does not provide health benefit plan coverage.
22 (V.T.I.C. Art. 3.51-6A, Sec. 6(d).)

23 CHAPTER 1253. CANCELLATION OF GROUP COVERAGE

24 IN CERTAIN CIRCUMSTANCES

25 SUBCHAPTER A. GENERAL PROVISIONS

26 Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON

27 CONTRACT RENEGOTIATION

[Sections 1253.002-1253.050 reserved for expansion]

SUBCHAPTER B. CONTINUATION OF GROUP ACCIDENT AND
HEALTH INSURANCE POLICIES DURING LABOR DISPUTE

Sec. 1253.051. APPLICABILITY OF SUBCHAPTER

Sec. 1253.052. CONTINUATION OF GROUP ACCIDENT AND HEALTH
INSURANCE DURING LABOR DISPUTE REQUIRED
FOR CERTAIN POLICIES

Sec. 1253.053. CONTRIBUTIONS IF POLICYHOLDER IS TRUSTEE

Sec. 1253.054. CONTRIBUTIONS IF POLICYHOLDER IS NOT TRUSTEE

Sec. 1253.055. PAYMENT OF CONTRIBUTION AND PREMIUM

Sec. 1253.056. PAST DUE PREMIUM

Sec. 1253.057. INDIVIDUAL PREMIUM RATE INCREASE

Sec. 1253.058. PREMIUM RATE CHANGE NOT LIMITED

Sec. 1253.059. LIMITATIONS ON CONTINUATION OF COVERAGE

Sec. 1253.060. OTHER PROVISIONS; COMMISSIONER APPROVAL
REQUIRED

CHAPTER 1253. CANCELLATION OF GROUP COVERAGE
IN CERTAIN CIRCUMSTANCES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON
CONTRACT RENEGOTIATION. (a) In this section, "health benefit
contract" means a contract providing group health care coverage for
employees that is delivered, issued for delivery, or renewed in
this state by:

(1) an insurance company;

(2) a group hospital service corporation operating
under Chapter 842; or

1 (3) a health maintenance organization operating under
2 Chapter 843.

3 (b) Subject to Subsection (c), if an employer in this state
4 agrees to renegotiate a health benefit contract, a change in the
5 renegotiated contract may not operate solely to terminate
6 eligibility with respect to any member of the group who, before the
7 contract was renegotiated:

8 (1) was covered under the contract; and

9 (2) had a sickness or injury for which a service was
10 being provided or a benefit was being paid under the contract.

11 (c) A renegotiated health benefit contract may include a
12 different durational or dollar limit or a different deductible
13 amount or amount of coinsurance applicable to a sickness or injury
14 for which a service was being provided or benefit was being paid
15 before the contract was renegotiated if that same or a similar limit
16 or amount applies to a service provided or benefit paid for a
17 similar sickness or a related condition or injury covered by the
18 contract. (V.T.I.C. Art. 3.51-6C.)

19 [Sections 1253.002-1253.050 reserved for expansion]

20 SUBCHAPTER B. CONTINUATION OF GROUP ACCIDENT AND

21 HEALTH INSURANCE POLICIES DURING LABOR DISPUTE

22 Sec. 1253.051. APPLICABILITY OF SUBCHAPTER. This
23 subchapter applies to a group accident and health insurance policy
24 that is delivered or issued for delivery in this state and as to
25 which any part of the premium is paid or is to be paid by an employer
26 under the terms of a collective bargaining agreement. (V.T.I.C.
27 Art. 3.51-8 (part), as amended Acts 77th Leg., R.S., Ch. 1419.)

1 Sec. 1253.052. CONTINUATION OF GROUP ACCIDENT AND HEALTH
2 INSURANCE DURING LABOR DISPUTE REQUIRED FOR CERTAIN POLICIES. An
3 insurer may not deliver or issue for delivery a policy subject to
4 this subchapter unless the policy provides that if the employees
5 covered by the policy stop work because of a labor dispute, coverage
6 continues under the policy, on timely payment of the premium, for
7 each employee who:

8 (1) is covered under the policy on the date the work
9 stoppage begins;

10 (2) continues to pay the employee's individual
11 contribution, subject to the conditions provided by this
12 subchapter; and

13 (3) assumes and pays during the work stoppage the
14 contribution due from the employer, subject to the conditions
15 provided by this subchapter. (V.T.I.C. Art. 3.51-8 (part), as
16 amended Acts 77th Leg., R.S., Ch. 1419.)

17 Sec. 1253.053. CONTRIBUTIONS IF POLICYHOLDER IS TRUSTEE.
18 (a) An employee's contribution for purposes of a policy as to which
19 the policyholder is a trustee or the trustees of a fund established
20 or maintained wholly or partly by the employer is the amount the
21 employee and employer would have been required to contribute to the
22 fund for the employee if:

23 (1) the work stoppage had not occurred; and

24 (2) the agreement requiring the employer to make
25 contributions to the fund were in effect.

26 (b) The policy may provide that continuation of coverage is
27 contingent on the collection of individual contributions by the

1 policyholder or the policyholder's agent. (V.T.I.C. Art. 3.51-8,
2 Subdivs. (b), (c) (part).)

3 Sec. 1253.054. CONTRIBUTIONS IF POLICYHOLDER IS NOT
4 TRUSTEE. (a) A policy as to which the policyholder is not a trustee
5 or the trustees of a fund established or maintained in whole or in
6 part by the employer must provide that the employee's individual
7 contribution:

8 (1) is the policy rate applicable:

9 (A) on the date the work stoppage begins; and

10 (B) to an individual in the class to which the
11 employee belongs as provided by the policy; or

12 (2) if the policy does not provide for a rate
13 applicable to an individual, is an amount equal to the amount
14 determined by dividing:

15 (A) the total monthly premium in effect under the
16 policy on the date the work stoppage begins; by

17 (B) the total number of insureds under the policy
18 on that date.

19 (b) The policy may provide that continuation of coverage
20 under this subchapter is contingent on the collection of individual
21 contributions by the union or unions representing the employees.
22 (V.T.I.C. Art. 3.51-8, Subdivs. (a), (c) (part).)

23 Sec. 1253.055. PAYMENT OF CONTRIBUTION AND PREMIUM. A
24 policy may provide that continuation of coverage for an employee
25 under the policy is contingent on timely payment of:

26 (1) contributions by the employee; and

27 (2) the premium by the entity responsible for

1 collecting the individual employee contributions. (V.T.I.C. Art.
2 3.51-8, Subdiv. (d).)

3 Sec. 1253.056. PAST DUE PREMIUM. (a) A policy may provide
4 that the continuation of coverage is contingent on payment of any
5 premium that:

6 (1) is unpaid on the date the work stoppage begins; and
7 (2) became due before the date the work stoppage
8 begins.

9 (b) A premium described by Subsection (a) must be paid
10 before the date the next premium becomes due under the policy.
11 (V.T.I.C. Art. 3.51-8, Subdiv. (h).)

12 Sec. 1253.057. INDIVIDUAL PREMIUM RATE INCREASE. (a) A
13 policy may provide that, during the period of a work stoppage, each
14 individual premium rate shall be increased by an amount not to
15 exceed 20 percent of the amount shown in the policy, or a greater
16 percentage as approved by the commissioner, to provide sufficient
17 compensation to the insurer to cover increased:

18 (1) administrative costs; and
19 (2) mortality and morbidity.

20 (b) If a policy provides for a premium rate increase in
21 accordance with this section, the amount of an employee's
22 contribution must be increased by the same percentage. (V.T.I.C.
23 Art. 3.51-8, Subdiv. (e).)

24 Sec. 1253.058. PREMIUM RATE CHANGE NOT LIMITED. (a) This
25 subchapter does not limit any right of the insurer under a policy to
26 increase or decrease a premium rate before, during, or after a work
27 stoppage if the insurer would be entitled to increase the premium

1 rate had a work stoppage not occurred.

2 (b) A change in a premium rate made in accordance with this
3 section takes effect on a date that is determined by the insurer in
4 accordance with the terms of the policy. (V.T.I.C. Art. 3.51-8,
5 Subdiv. (f).)

6 Sec. 1253.059. LIMITATIONS ON CONTINUATION OF COVERAGE.
7 This subchapter does not require the continuation of coverage under
8 a policy for any loss of time benefits included in the policy or the
9 continuation of other coverage for a period:

10 (1) longer than six months after a work stoppage
11 occurs;

12 (2) beyond the time that 75 percent of the covered
13 employees continue the coverage; or

14 (3) as to an individual covered employee, beyond the
15 time that the employee takes a full-time job with another employer.
16 (V.T.I.C. Art. 3.51-8, Subdiv. (i).)

17 Sec. 1253.060. OTHER PROVISIONS; COMMISSIONER APPROVAL
18 REQUIRED. A policy may contain any other provision relating to
19 continuation of policy coverage during a work stoppage that the
20 commissioner approves. (V.T.I.C. Art. 3.51-8, Subdiv. (g).)

21 CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH AND
22 ACCIDENT COVERAGE

23 Sec. 1254.001. NOTICE OF RATE INCREASE

24 CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH AND
25 ACCIDENT COVERAGE

26 Sec. 1254.001. NOTICE OF RATE INCREASE. (a) In this
27 section, "insurer" means:

- 1 (1) a life insurance company;
- 2 (2) a health insurance company;
- 3 (3) an accident insurance company;
- 4 (4) a general casualty company;
- 5 (5) a mutual life insurance company or other mutual
6 insurance company;
- 7 (6) a mutual or natural premium life insurance
8 company;
- 9 (7) a Lloyd's plan;
- 10 (8) a reciprocal or interinsurance exchange;
- 11 (9) a fraternal benefit society;
- 12 (10) a local mutual aid association; or
- 13 (11) a group hospital service corporation.

14 (b) Not later than the 31st day before the date on which a
15 premium rate increase takes effect on a group policy of health
16 insurance, accident and health insurance, or life, health, and
17 accident insurance delivered or issued for delivery in this state
18 by an insurer, the insurer shall give written notice to the
19 policyholder of:

- 20 (1) the amount of the increase; and
- 21 (2) the date on which the increase is to take effect.

22 (c) A health maintenance organization shall give notice of
23 an increase in subscriber charges and service fees under a group
24 contract or coverage in the same manner as is required of an insurer
25 under Subsection (b).

26 (d) An insurer that issues a group policy described by
27 Subsection (b) to a multiple employer trust shall give the notice

1 required by that subsection to the trustee or group policyholder.

2 (e) The notice required by this section must be based on
3 coverage in effect on the date of the notice.

4 (f) This section may not be construed to prevent an insurer
5 or health maintenance organization, at the request of a
6 policyholder or contract holder, from negotiating a change in
7 benefits or rates after delivery of the notice required by this
8 section. (V.T.I.C. Art. 3.51-10, as amended Acts 77th Leg., R.S.,
9 Ch. 1419.)

10 [Chapters 1255-1270 reserved for expansion]

11 SUBTITLE C. MANAGED CARE

12 CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE

13 ORGANIZATIONS; EVIDENCE OF COVERAGE; CHARGES

14 SUBCHAPTER A. GENERAL PROVISIONS

15 Sec. 1271.001. APPLICABILITY OF DEFINITIONS

16 Sec. 1271.002. RIGHT TO EVIDENCE OF COVERAGE; ISSUANCE

17 Sec. 1271.003. EVIDENCE OF COVERAGE NOT HEALTH INSURANCE

18 POLICY

19 Sec. 1271.004. INDIVIDUAL HEALTH CARE PLAN

20 Sec. 1271.005. APPLICABILITY OF OTHER LAW

21 Sec. 1271.006. BENEFITS TO DEPENDENT CHILD AND GRANDCHILD

22 Sec. 1271.007. RELIGIOUS CONVICTIONS

23 [Sections 1271.008-1271.050 reserved for expansion]

24 SUBCHAPTER B. CONTENTS OF EVIDENCE OF COVERAGE

25 Sec. 1271.051. EVIDENCE OF COVERAGE: CONTRACT AND

26 CERTIFICATE REQUIREMENTS

27 Sec. 1271.052. INFORMATION ABOUT BENEFITS AND

LIMITATIONS

Sec. 1271.053. INFORMATION ABOUT OBTAINING SERVICES

Sec. 1271.054. INFORMATION ABOUT COMPLAINTS AND APPEALS

Sec. 1271.055. OUT-OF-NETWORK SERVICES

Sec. 1271.056. UNFAIR OR DECEPTIVE PROVISIONS

AND STATEMENTS PROHIBITED

[Sections 1271.057-1271.100 reserved for expansion]

SUBCHAPTER C. COMMISSIONER APPROVAL

Sec. 1271.101. APPROVAL OF FORM OF EVIDENCE OF COVERAGE

OR GROUP CONTRACT

Sec. 1271.102. PROCEDURES FOR APPROVAL OF FORM OF EVIDENCE

OF COVERAGE OR GROUP CONTRACT; WITHDRAWAL

OF APPROVAL

Sec. 1271.103. WITHDRAWAL OF APPROVAL OF FORM

Sec. 1271.104. INFORMATION REQUIRED BY COMMISSIONER

[Sections 1271.105-1271.150 reserved for expansion]

SUBCHAPTER D. CERTAIN BENEFITS REQUIRED

Sec. 1271.151. PROVISION OF BASIC HEALTH CARE SERVICES

Sec. 1271.152. STANDARDS FOR BASIC HEALTH CARE

SERVICES

Sec. 1271.153. PERIODIC HEALTH EVALUATIONS

Sec. 1271.154. WELL-CHILD CARE FROM BIRTH

Sec. 1271.155. EMERGENCY CARE

Sec. 1271.156. BENEFITS FOR REHABILITATION SERVICES AND

THERAPIES

[Sections 1271.157-1271.200 reserved for expansion]

SUBCHAPTER E. CHOICE OF PRIMARY CARE PHYSICIAN

FOR CERTAIN ENROLLEES

Sec. 1271.201. DESIGNATION OF SPECIALIST AS PRIMARY
CARE PHYSICIAN

Sec. 1271.202. APPEAL

Sec. 1271.203. EFFECTIVE DATE OF DESIGNATION

[Sections 1271.204-1271.250 reserved for expansion]

SUBCHAPTER F. SCHEDULE OF CHARGES

Sec. 1271.251. APPROVAL OF FORMULA OR METHOD FOR
COMPUTING SCHEDULE OF CHARGES

Sec. 1271.252. CONSIDERATION OF INDIVIDUAL HEALTH
STATUS PROHIBITED

Sec. 1271.253. INFORMATION REQUIRED BY COMMISSIONER

[Sections 1271.254-1271.300 reserved for expansion]

SUBCHAPTER G. CONTINUATION OF COVERAGE, CONVERSION
CONTRACTS, AND RENEWAL

Sec. 1271.301. ENTITLEMENT TO CONTINUATION OF GROUP
COVERAGE

Sec. 1271.302. REQUEST FOR CONTINUED COVERAGE; DEADLINE

Sec. 1271.303. PAYMENT FOR CONTINUED COVERAGE

Sec. 1271.304. TERMINATION OF CONTINUED COVERAGE

Sec. 1271.305. NOTIFICATION OF RISK POOL ELIGIBILITY

Sec. 1271.306. CONVERSION CONTRACTS

Sec. 1271.307. RENEWABILITY OF COVERAGE: INDIVIDUAL
HEALTH CARE PLANS AND CONVERSION
CONTRACTS

CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE

ORGANIZATIONS; EVIDENCE OF COVERAGE; CHARGES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1271.001. APPLICABILITY OF DEFINITIONS. In this chapter, terms defined by Section 843.002 have the meanings assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts 77th Leg., R.S., Ch. 1419.)

Sec. 1271.002. RIGHT TO EVIDENCE OF COVERAGE; ISSUANCE. (a) Each enrollee residing in this state is entitled to evidence of coverage under a health care plan.

(b) The health maintenance organization shall issue the evidence of coverage, except as provided by Subsection (c).

(c) If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage. (V.T.I.C. Art. 20A.09, Secs. (a), as amended Acts 75th Leg., R.S., Ch. 905; (a)(1), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.003. EVIDENCE OF COVERAGE NOT HEALTH INSURANCE POLICY. An evidence of coverage is not a health insurance policy as that term is defined by this code. (V.T.I.C. Art. 20A.09, Secs. (o), as amended Acts 75th Leg., R.S., Ch. 905; (g), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.004. INDIVIDUAL HEALTH CARE PLAN. (a) In this section, "individual health care plan" means a health care plan:

(1) that provides health care services for individuals and their dependents;

(2) under which an enrollee:

1 (A) pays the premium; and

2 (B) is not covered under the contract in
3 accordance with a continuation of services or continuation of
4 benefits requirement applicable under federal or state law; and

5 (3) in which the evidence of coverage meets the
6 requirements of the definition of "basic health care services"
7 provided by Section 843.002.

8 (b) A health maintenance organization may provide an
9 individual health care plan in accordance with this section and
10 Section 1271.307.

11 (c) A health maintenance organization may limit enrollment
12 in an individual health care plan to individuals who reside or work
13 within the service area for the plan's network.

14 (d) The commissioner may adopt rules necessary to implement
15 this section and to meet the minimum requirements of federal law,
16 including regulations. (V.T.I.C. Art. 20A.09, Sec. (1) (part), as
17 added Acts 75th Leg., R.S., Ch. 837.)

18 Sec. 1271.005. APPLICABILITY OF OTHER LAW. (a) Chapters
19 1368 and 1652 apply to a health maintenance organization other than
20 a health maintenance organization that offers only a single health
21 care service plan.

22 (b) Subchapter B, Chapter 1355, applies to a health
23 maintenance organization providing benefits for mental health
24 treatment in a residential treatment center for children and
25 adolescents or crisis stabilization unit to the extent that:

26 (1) Subchapter B, Chapter 1355, does not conflict with
27 this chapter, Chapter 843, or Subchapter A, Chapter 1452; and

1 (2) the residential treatment center for children and
2 adolescents or crisis stabilization unit is located within the
3 service area of the health maintenance organization and is subject
4 to inspection and review as required by this chapter, Chapter 843,
5 or Subchapter A, Chapter 1452, or rules adopted under this chapter,
6 Chapter 843, or Subchapter A, Chapter 1452.

7 (c) A health maintenance organization shall comply with
8 Subchapter B, Chapter 542, with respect to prompt payment to an
9 enrollee.

10 (d) Notwithstanding any other law, Subchapter C, Chapter
11 1355, applies to a group contract issued by a health maintenance
12 organization.

13 (e) Notwithstanding any other law, Section 1201.062 applies
14 to an evidence of coverage issued by a health maintenance
15 organization. (V.T.I.C. Art. 3.70-1, Sec. (F)(5) (part); Art.
16 3.70-2, Secs. (F) (part), (L) (part), as amended Acts 77th Leg.,
17 R.S., Chs. 396 and 1027; Art. 20A.09, Secs. (n), (p), (q), as
18 amended Acts 75th Leg., R.S., Ch. 905; (e), (f), (h), (i), as
19 amended Acts 75th Leg., R.S., Ch. 1026; Art. 20A.09Z.)

20 Sec. 1271.006. BENEFITS TO DEPENDENT CHILD AND GRANDCHILD.

21 (a) If children are eligible for coverage under the terms of an
22 evidence of coverage, any limiting age applicable to an unmarried
23 child of an enrollee, including an unmarried grandchild of an
24 enrollee, is 25 years of age. The limiting age applicable to a
25 child must be stated in the evidence of coverage.

26 (b) A health maintenance organization may provide benefits
27 under a health care plan to an enrollee's dependent grandchild who

1 is living with and in the household of the enrollee. (V.T.I.C. Art.
2 20A.09H, Sec. (a), as redesignated and amended Acts 77th Leg.,
3 R.S., Ch. 396; Art. 20A.09H, as redesignated and amended Acts 77th
4 Leg., R.S., Ch. 1027.)

5 Sec. 1271.007. RELIGIOUS CONVICTIONS. (a) This chapter,
6 Chapters 843, 1272, and 1367, and Subchapter A, Chapter 1452, do not
7 require a health maintenance organization, physician, or provider
8 to recommend, offer advice concerning, pay for, provide, assist in,
9 perform, arrange, or participate in providing or performing any
10 health care service that violates the religious convictions of the
11 health maintenance organization, physician, or provider.

12 (b) A health maintenance organization that limits or denies
13 health care services under this section shall state the limitations
14 in the evidence of coverage as required by Section 1271.052.
15 (V.T.I.C. Art. 20A.09, Sec. (m), as added Acts 75th Leg., R.S., Ch.
16 1026.)

17 [Sections 1271.008-1271.050 reserved for expansion]

18 SUBCHAPTER B. CONTENTS OF EVIDENCE OF COVERAGE

19 Sec. 1271.051. EVIDENCE OF COVERAGE: CONTRACT AND
20 CERTIFICATE REQUIREMENTS. (a) An evidence of coverage that is a
21 contract must contain a clear and complete statement of the
22 information required by Sections 1271.052, 1271.053, and 1271.054.

23 (b) An evidence of coverage that is a certificate must
24 contain a reasonably complete facsimile of the information required
25 by Sections 1271.052, 1271.053, and 1271.054. (V.T.I.C. Art.
26 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905;
27 (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.052. INFORMATION ABOUT BENEFITS AND LIMITATIONS.

An evidence of coverage must state:

(1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(2) the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan; and

(3) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or copayment feature. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.053. INFORMATION ABOUT OBTAINING SERVICES. An evidence of coverage must indicate where and in what manner information is available about how to obtain services. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.054. INFORMATION ABOUT COMPLAINTS AND APPEALS.

(a) An evidence of coverage must contain a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including:

(1) the enrollee's right to appeal denial of an adverse determination to an independent review organization; and

(2) the procedures for appealing to an independent review organization.

1 (b) A health maintenance organization may indicate a
2 subsequent change to the methods for resolving enrollee complaints
3 in a separate document issued to the enrollee. (V.T.I.C. Art.
4 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905;
5 (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

6 Sec. 1271.055. OUT-OF-NETWORK SERVICES. (a) An evidence
7 of coverage must contain a provision regarding non-network
8 physicians and providers in accordance with the requirements of
9 this section.

10 (b) If medically necessary covered services are not
11 available through network physicians or providers, the health
12 maintenance organization, on the request of a network physician or
13 provider and within a reasonable period, shall:

14 (1) allow referral to a non-network physician or
15 provider; and

16 (2) fully reimburse the non-network physician or
17 provider at the usual and customary rate or at an agreed rate.

18 (c) Before denying a request for a referral to a non-network
19 physician or provider, a health maintenance organization must
20 provide for a review conducted by a specialist of the same or
21 similar type of specialty as the physician or provider to whom the
22 referral is requested. (V.T.I.C. Art. 20A.09, Secs. (d), (f), as
23 amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended
24 Acts 75th Leg., R.S., Ch. 1026.)

25 Sec. 1271.056. UNFAIR OR DECEPTIVE PROVISIONS AND
26 STATEMENTS PROHIBITED. An evidence of coverage may not contain a
27 provision or statement that:

1 (1) is unjust, unfair, inequitable, misleading, or
2 deceptive;

3 (2) encourages misrepresentation; or

4 (3) is untrue, misleading, or deceptive within the
5 meaning of Section 843.204. (V.T.I.C. Art. 20A.09, Secs. (c), as
6 amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended
7 Acts 75th Leg., R.S., Ch. 1026.)

8 [Sections 1271.057-1271.100 reserved for expansion]

9 SUBCHAPTER C. COMMISSIONER APPROVAL

10 Sec. 1271.101. APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR
11 GROUP CONTRACT. (a) An evidence of coverage or an amendment of an
12 evidence of coverage may not be issued or delivered to a person in
13 this state until the form of the evidence of coverage or amendment
14 has been filed with and approved by the commissioner.

15 (b) Except as provided by Subsection (c), the form of an
16 evidence of coverage or group contract to be used in this state or
17 an amendment to one of those forms is subject to the filing and
18 approval requirements of Section 1271.102.

19 (c) If the form of an evidence of coverage or group contract
20 or of an amendment to one of those forms is subject to the
21 jurisdiction of the commissioner under laws governing health
22 insurance or group hospital service corporations, the filing and
23 approval provisions of those laws apply to that form. However,
24 Subchapters B and E apply to that form to the extent that laws
25 governing health insurance or group hospital service corporations
26 do not apply to the requirements of Subchapters B and E. (V.T.I.C.
27 Art. 20A.09, Secs. (b), (j), as amended Acts 75th Leg., R.S., Ch.

905; (a)(2), (5), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.102. PROCEDURES FOR APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT; WITHDRAWAL OF APPROVAL. (a) The commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of this chapter.

(b) If the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The commissioner may, by written notice, extend the period for approval or disapproval as necessary for proper consideration of the filing for not more than an additional 30 days.

(c) If the commissioner disapproves a form, the commissioner shall notify the person who filed the form of the reason for the disapproval.

(d) A hearing on the disapproval of a form shall be granted not later than the 30th day after the date the person filing the form makes a written request for a hearing. (V.T.I.C. Art. 20A.09, Secs. (1) (part), as amended Acts 75th Leg., R.S., Ch. 905; (c) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Sec. 1271.103. WITHDRAWAL OF APPROVAL OF FORM. (a) After notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates this chapter, Chapter 843, 1272, or 1367, or Subchapter A, Chapter 1452, or a rule adopted by the commissioner.

(b) If the commissioner withdraws approval of a form under

1 this section, the form may not be issued until it is approved.
2 (V.T.I.C. Art. 20A.09, Secs. (l) (part), as amended Acts 75th Leg.,
3 R.S., Ch. 905; (c) (part), as amended Acts 75th Leg., R.S., Ch.
4 1026.)

5 Sec. 1271.104. INFORMATION REQUIRED BY COMMISSIONER. The
6 commissioner may require the submission of any relevant information
7 the commissioner considers necessary in determining whether to
8 approve or disapprove a filing under this subchapter. (V.T.I.C.
9 Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905;
10 (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

11 [Sections 1271.105-1271.150 reserved for expansion]

12 SUBCHAPTER D. CERTAIN BENEFITS REQUIRED

13 Sec. 1271.151. PROVISION OF BASIC HEALTH CARE SERVICES. A
14 health maintenance organization that offers a basic health care
15 plan shall provide or arrange for basic health care services to its
16 enrollees as needed and without limitation as to time and cost other
17 than any limitation prescribed by rule of the commissioner.
18 (V.T.I.C. Art. 20A.09, Sec. (l), as added Acts 75th Leg., R.S., Ch.
19 1026.)

20 Sec. 1271.152. STANDARDS FOR BASIC HEALTH CARE SERVICES.
21 The commissioner may adopt minimum standards relating to basic
22 health care services. (V.T.I.C. Art. 20A.09, Sec. (n), as added
23 Acts 75th Leg., R.S., Ch. 1026.)

24 Sec. 1271.153. PERIODIC HEALTH EVALUATIONS. (a) The basic
25 health care services provided under an evidence of coverage must
26 include periodic health evaluations for each adult enrollee.

27 (b) The services provided under this section must include a

1 health risk assessment at least once every three years and, for a
2 female enrollee, an annual well-woman examination provided in
3 accordance with Subchapter F, Chapter 1451.

4 (c) This section does not apply to an evidence of coverage
5 for a limited health care service plan or a single health care
6 service plan. (V.T.I.C. Art. 20A.09B.)

7 Sec. 1271.154. WELL-CHILD CARE FROM BIRTH. (a) In this
8 section, "well-child care from birth" has the meaning used under
9 Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1),
10 and its subsequent amendments. The term includes newborn screening
11 required by the Texas Department of Health.

12 (b) A health maintenance organization shall ensure that
13 each health care plan provided by the health maintenance
14 organization includes well-child care from birth that complies
15 with:

16 (1) federal requirements adopted under Chapter XI,
17 Public Health Service Act (42 U.S.C. Section 300e et seq.), and its
18 subsequent amendments; and

19 (2) the rules adopted by the Texas Department of
20 Health to implement those requirements. (V.T.I.C. Art. 20A.09E.)

21 Sec. 1271.155. EMERGENCY CARE. (a) A health maintenance
22 organization shall pay for emergency care performed by non-network
23 physicians or providers at the usual and customary rate or at an
24 agreed rate.

25 (b) A health care plan of a health maintenance organization
26 must provide the following coverage of emergency care:

27 (1) a medical screening examination or other

1 evaluation required by state or federal law necessary to determine
2 whether an emergency medical condition exists shall be provided to
3 covered enrollees in a hospital emergency facility or comparable
4 facility;

5 (2) necessary emergency care shall be provided to
6 covered enrollees, including the treatment and stabilization of an
7 emergency medical condition; and

8 (3) services originated in a hospital emergency
9 facility or comparable facility following treatment or
10 stabilization of an emergency medical condition shall be provided
11 to covered enrollees as approved by the health maintenance
12 organization, subject to Subsections (c) and (d).

13 (c) A health maintenance organization shall approve or deny
14 coverage of poststabilization care as requested by a treating
15 physician or provider within the time appropriate to the
16 circumstances relating to the delivery of the services and the
17 condition of the patient, but not to exceed one hour from the time
18 of the request.

19 (d) A health maintenance organization shall respond to
20 inquiries from a treating physician or provider in compliance with
21 this provision in the health care plan of the health maintenance
22 organization.

23 (e) A health care plan of a health maintenance organization
24 shall comply with this section regardless of whether the physician
25 or provider furnishing the emergency care has a contractual or
26 other arrangement with the health maintenance organization to
27 provide items or services to covered enrollees. (V.T.I.C. Art.

20A.09Y, as added Acts 77th Leg., R.S., Ch. 1419.)

Sec. 1271.156. BENEFITS FOR REHABILITATION SERVICES AND THERAPIES. (a) If benefits are provided for rehabilitation services and therapies under an evidence of coverage, the provision of a rehabilitation service or therapy that, in the opinion of a physician, is medically necessary may not be denied, limited, or terminated if the service or therapy meets or exceeds treatment goals for the enrollee.

(b) For an enrollee with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration. (V.T.I.C. Art. 20A.09, Sec. (a)(4), as amended Acts 75th Leg., R.S., Ch. 1026.)

[Sections 1271.157-1271.200 reserved for expansion]

SUBCHAPTER E. CHOICE OF PRIMARY CARE PHYSICIAN
FOR CERTAIN ENROLLEES

Sec. 1271.201. DESIGNATION OF SPECIALIST AS PRIMARY CARE PHYSICIAN. (a) An evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the health maintenance organization's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

(b) The application must:

(1) include information specified by the health maintenance organization, including certification of the medical need; and

(2) be signed by the enrollee and the nonprimary care physician specialist interested in serving as the enrollee's

1 primary care physician.

2 (c) To be eligible to serve as the enrollee's primary care
3 physician, a physician specialist must:

4 (1) meet the health maintenance organization's
5 requirements for primary care physician participation; and

6 (2) agree to accept the responsibility to coordinate
7 all of the enrollee's health care needs. (V.T.I.C. Art. 20A.09,
8 Secs. (d), (g), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3)
9 (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

10 Sec. 1271.202. APPEAL. If a health maintenance
11 organization denies a request under Section 1271.201, the enrollee
12 may appeal the decision through the health maintenance
13 organization's established complaint and appeals process.
14 (V.T.I.C. Art. 20A.09, Secs. (h), as amended Acts 75th Leg., R.S.,
15 Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

16 Sec. 1271.203. EFFECTIVE DATE OF DESIGNATION. (a) The
17 effective date of the designation of a nonprimary care physician
18 specialist as an enrollee's primary care physician under Section
19 1271.201 may not be applied retroactively.

20 (b) A health maintenance organization may not reduce the
21 amount of compensation owed to the original primary care physician
22 for services provided before the date of the new designation.
23 (V.T.I.C. Art. 20A.09, Secs. (i), as amended Acts 75th Leg., R.S.,
24 Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

25 [Sections 1271.204-1271.250 reserved for expansion]

26 SUBCHAPTER F. SCHEDULE OF CHARGES

27 Sec. 1271.251. APPROVAL OF FORMULA OR METHOD FOR COMPUTING

1 SCHEDULE OF CHARGES. (a) The formula or method for computing the
2 schedule of charges for enrollee coverage for health care services
3 must be filed with the commissioner before the formula or method is
4 used in conjunction with a health care plan.

5 (b) The formula or method must be established in accordance
6 with actuarial principles for the various categories of enrollees.
7 The filing of the method or formula must contain:

8 (1) a statement by a qualified actuary that certifies
9 that the formula or method is appropriate; and

10 (2) supporting information that the commissioner
11 considers adequate.

12 (c) The formula or method must produce charges that are not
13 excessive, inadequate, or unfairly discriminatory. Benefits must
14 be reasonable with respect to the rates produced by the formula or
15 method. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts
16 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg.,
17 R.S., Ch. 1026.)

18 Sec. 1271.252. CONSIDERATION OF INDIVIDUAL HEALTH STATUS
19 PROHIBITED. The charges resulting from the application of a
20 formula or method described by Section 1271.251 may not be altered
21 for an individual enrollee based on the status of that enrollee's
22 health. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts
23 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg.,
24 R.S., Ch. 1026.)

25 Sec. 1271.253. INFORMATION REQUIRED BY COMMISSIONER. The
26 commissioner may require the submission of any relevant information
27 the commissioner considers necessary in determining whether to

1 approve or disapprove a filing under this subchapter. (V.T.I.C.
2 Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905;
3 (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

4 [Sections 1271.254-1271.300 reserved for expansion]

5 SUBCHAPTER G. CONTINUATION OF COVERAGE, CONVERSION
6 CONTRACTS, AND RENEWAL

7 Sec. 1271.301. ENTITLEMENT TO CONTINUATION OF GROUP
8 COVERAGE. (a) In this section, "involuntary termination for cause"
9 does not include termination for any health-related reason.

10 (b) A health maintenance organization shall provide a group
11 coverage continuation privilege as required by and subject to the
12 eligibility provisions of this subchapter.

13 (c) An enrollee is entitled to continue group coverage as
14 provided by this subchapter if:

15 (1) the enrollee's coverage under a group contract is
16 terminated for any reason except involuntary termination for cause;
17 and

18 (2) the enrollee for at least three consecutive months
19 immediately before the termination of coverage has been
20 continuously covered under the group contract and under any
21 previous group contract providing similar services and benefits
22 that the current group contract replaced. (V.T.I.C. Art. 20A.09,
23 Sec. (k)(A) (part), as added Acts 75th Leg., R.S., Ch. 837.)

24 Sec. 1271.302. REQUEST FOR CONTINUED COVERAGE; DEADLINE.
25 An enrollee must make a written election to continue group coverage
26 under this subchapter and pay the first contribution required to
27 establish contributions on an advance monthly basis to the employer

1 or group contract holder not later than the 31st day after the later
2 of:

3 (1) the date the group coverage would otherwise
4 terminate; or

5 (2) the date the enrollee is given notice of the right
6 of continuation by the employer or group contract holder.
7 (V.T.I.C. Art. 20A.09, Secs. (k)(A)(1), (3), as added Acts 75th
8 Leg., R.S., Ch. 837.)

9 Sec. 1271.303. PAYMENT FOR CONTINUED COVERAGE. (a) An
10 enrollee electing continuation of group coverage must pay to the
11 employer or group contract holder the amount of contribution
12 required by the employer or group contract holder, plus an amount
13 equal to two percent of the group rate for the coverage being
14 continued under the group contract.

15 (b) The enrollee must make the payment in advance on a
16 monthly basis on the due date of each payment. (V.T.I.C. Art.
17 20A.09, Sec. (k)(A)(2), as added Acts 75th Leg., R.S., Ch. 837.)

18 Sec. 1271.304. TERMINATION OF CONTINUED COVERAGE. Group
19 continued coverage under this subchapter may not terminate until
20 the earliest of:

21 (1) the end of the six-month period after the date the
22 election to continue coverage is made;

23 (2) the date on which failure to make timely payments
24 terminates coverage;

25 (3) the date on which the enrollee is covered for
26 similar services and benefits by any other plan or program,
27 including a hospital, surgical, medical, or major medical expense

1 insurance policy, hospital or medical service subscriber contract,
2 or medical practice or other prepayment plan; or

3 (4) the date on which the group coverage terminates in
4 its entirety. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(4), as added Acts
5 75th Leg., R.S., Ch. 837.)

6 Sec. 1271.305. NOTIFICATION OF RISK POOL ELIGIBILITY. (a)
7 At least 30 days before the end of the six-month period after the
8 date an enrollee elects to continue group coverage, the health
9 maintenance organization shall notify the enrollee that the
10 enrollee may be eligible for coverage under the Texas Health
11 Insurance Risk Pool as provided by Chapter 1506.

12 (b) The health maintenance organization shall provide to
13 the enrollee the address for applying to the pool for coverage.
14 (V.T.I.C. Art. 20A.09, Sec. (k)(A)(5), as added Acts 75th Leg.,
15 R.S., Ch. 837.)

16 Sec. 1271.306. CONVERSION CONTRACTS. (a) A health
17 maintenance organization may offer to each enrollee a conversion
18 contract.

19 (b) A health maintenance organization shall issue the
20 conversion contract without evidence of insurability if written
21 application for the contract and payment of the first premium are
22 made not later than the 31st day after the date of termination of
23 coverage.

24 (c) A conversion contract must meet the minimum standards
25 for services and benefits for conversion contracts. The
26 commissioner shall adopt rules to prescribe the minimum standards
27 for services and benefits applicable to conversion contracts.

1 (d) The premium for a conversion contract shall be
2 determined in accordance with the health maintenance
3 organization's premium rates for coverage provided under the group
4 contract or plan. The premium may be based on the geographic
5 location of each person to be covered and must be based on the type
6 of conversion contract and the coverage provided by the contract.
7 The premium may not exceed 200 percent of the premium rates for the
8 same coverage provided under a group contract or plan. (V.T.I.C.
9 Art. 20A.09, Secs. (k)(B), (C), as added Acts 75th Leg., R.S., Ch.
10 837.)

11 Sec. 1271.307. RENEWABILITY OF COVERAGE: INDIVIDUAL HEALTH
12 CARE PLANS AND CONVERSION CONTRACTS. (a) In this section,
13 "individual health care plan" has the meaning assigned by Section
14 1271.004.

15 (b) An individual health care plan or a conversion contract
16 that provides health care services to an enrollee is renewable at
17 the option of the enrollee. A health maintenance organization may
18 decline to renew an individual health care plan or conversion
19 contract only:

20 (1) for failure to pay premiums or contributions in
21 accordance with the terms of the plan or because the issuer of the
22 plan has not received timely premium payments;

23 (2) for fraud or intentional misrepresentation;

24 (3) because the health maintenance organization
25 ceases to offer coverage in the individual market in accordance
26 with rules established by the commissioner;

27 (4) because the enrollee no longer resides or works in

1 the area in which the health maintenance organization is authorized
2 to provide coverage, if coverage under the plan is terminated
3 uniformly for this reason without regard to any factor related to
4 the health status of a covered enrollee; or

5 (5) in accordance with applicable federal law,
6 including regulations.

7 (c) The commissioner may adopt rules necessary to implement
8 this section and to meet the minimum requirements of federal law,
9 including regulations. (V.T.I.C. Art. 20A.09, Sec. (1) (part), as
10 added Acts 75th Leg., R.S., Ch. 837.)

11 CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY

12 HEALTH MAINTENANCE ORGANIZATION

13 SUBCHAPTER A. GENERAL PROVISIONS

14 Sec. 1272.001. DEFINITIONS

15 Sec. 1272.002. COMPLIANCE OF LIMITED PROVIDER NETWORK

16 OR DELEGATED ENTITY WITH CERTAIN

17 LEGAL REQUIREMENTS

18 [Sections 1272.003-1272.050 reserved for expansion]

19 SUBCHAPTER B. DELEGATION AGREEMENTS

20 Sec. 1272.051. APPLICABILITY OF SUBCHAPTER

21 Sec. 1272.052. DELEGATION AGREEMENT REQUIRED

22 Sec. 1272.053. MONITORING PLAN

23 Sec. 1272.054. REQUIREMENTS FOR TERMINATION

24 WITHOUT CAUSE

25 Sec. 1272.055. COLLECTION OF PAYMENTS

26 Sec. 1272.056. COMPLIANCE WITH STATUTORY AND

27 REGULATORY REQUIREMENTS

1 Sec. 1272.057. EXAMINATION BY COMMISSIONER

2 Sec. 1272.058. INFORMATION RELATING TO DELEGATED

3 THIRD PARTY

4 Sec. 1272.059. CONTRACTS WITH DELEGATED THIRD PARTY

5 Sec. 1272.060. UTILIZATION REVIEW

6 Sec. 1272.061. RIGHTS AND DUTIES OF DELEGATED ENTITY

7 AND HEALTH MAINTENANCE ORGANIZATION

8 Sec. 1272.062. INFORMATION TO BE PROVIDED BY DELEGATED

9 ENTITY TO HEALTH MAINTENANCE ORGANIZATION

10 Sec. 1272.063. ENROLLEE COMPLAINTS

11 Sec. 1272.064. RULES

12 [Sections 1272.065-1272.100 reserved for expansion]

13 SUBCHAPTER C. INFORMATION REPORTING TO DELEGATED ENTITY

14 Sec. 1272.101. APPLICABILITY OF SUBCHAPTER

15 Sec. 1272.102. REPORTING REQUIRED

16 Sec. 1272.103. RULES

17 [Sections 1272.104-1272.150 reserved for expansion]

18 SUBCHAPTER D. RESERVE REQUIREMENTS

19 Sec. 1272.151. APPLICABILITY OF SUBCHAPTER

20 Sec. 1272.152. GENERAL RESERVE REQUIREMENTS

21 Sec. 1272.153. RESERVE REQUIREMENTS FOR MEDICAL CARE

22 AND HOSPITAL OR INSTITUTIONAL SERVICES

23 Sec. 1272.154. RESERVE REQUIREMENTS FOR PRESCRIPTION DRUGS

24 Sec. 1272.155. FORM OF RESERVES

25 Sec. 1272.156. ESCROW ACCOUNT

26 [Sections 1272.157-1272.200 reserved for expansion]

27 SUBCHAPTER E. COMPLIANCE

1 Sec. 1272.201. APPLICABILITY OF SUBCHAPTER

2 Sec. 1272.202. NOTICE OF NONCOMPLIANCE OR HAZARDOUS
3 OPERATING CONDITION

4 Sec. 1272.203. RESPONSE TO NOTICE

5 Sec. 1272.204. COOPERATION OF HEALTH MAINTENANCE
6 ORGANIZATION

7 Sec. 1272.205. EXAMINATION BY DEPARTMENT; REPORT

8 Sec. 1272.206. RESPONSE TO DEPARTMENT REPORT; CORRECTIVE
9 PLAN

10 Sec. 1272.207. REQUEST FOR CORRECTIVE ACTION

11 Sec. 1272.208. AUTHORITY OF COMMISSIONER TO ISSUE ORDER

12 Sec. 1272.209. PUBLIC DOCUMENTS

13 Sec. 1272.210. RECORD OF COMPLAINTS; REPORT

14 Sec. 1272.211. RULES

15 [Sections 1272.212-1272.250 reserved for expansion]

16 SUBCHAPTER F. PENALTIES

17 Sec. 1272.251. APPLICABILITY OF SUBCHAPTER

18 Sec. 1272.252. SUSPENSION OR REVOCATION OF LICENSE OF
19 THIRD-PARTY ADMINISTRATOR OR
20 UTILIZATION REVIEW AGENT

21 Sec. 1272.253. SANCTIONS AND PENALTIES AGAINST HEALTH
22 MAINTENANCE ORGANIZATION

23 Sec. 1272.254. CONTRACTUAL PENALTIES REQUIRED

24 Sec. 1272.255. RULES

25 [Sections 1272.256-1272.300 reserved for expansion]

26 SUBCHAPTER G. PROVISION OF SERVICES BY LIMITED PROVIDER NETWORK
27 OR DELEGATED ENTITY

1 Sec. 1272.301. ACCESS TO OUT-OF-NETWORK SERVICES

2 Sec. 1272.302. CONTINUITY OF CARE

3 CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY

4 HEALTH MAINTENANCE ORGANIZATION

5 SUBCHAPTER A. GENERAL PROVISIONS

6 Sec. 1272.001. DEFINITIONS. (a) In this chapter:

7 (1) "Delegated entity" means an entity, other than a
8 health maintenance organization authorized to engage in business
9 under Chapter 843, that by itself, or through subcontracts with one
10 or more entities, undertakes to arrange for or provide medical care
11 or health care to an enrollee in exchange for a predetermined
12 payment on a prospective basis and that accepts responsibility for
13 performing on behalf of the health maintenance organization a
14 function regulated by this chapter, Chapter 843, 1271, or 1367, or
15 Subchapter A, Chapter 1452. The term does not include:

16 (A) an individual physician; or

17 (B) a group of employed physicians, practicing
18 medicine under one federal tax identification number, whose total
19 claims paid to providers not employed by the group constitute less
20 than 20 percent of the group's total collected revenue computed on a
21 calendar year basis.

22 (2) "Delegated network" means a delegated entity that
23 assumes total financial risk for more than one of the following
24 categories of health care services: medical care, hospital or other
25 institutional services, or prescription drugs, as defined by
26 Section 551.003, Occupations Code. The term does not include a
27 delegated entity that shares risk for a category of services with a

1 health maintenance organization.

2 (3) "Delegated third party" means a third party other
3 than a delegated entity that contracts with a delegated entity,
4 either directly or through another third party, to:

5 (A) accept responsibility for performing a
6 function regulated by this chapter, Chapter 843, 1271, or 1367, or
7 Subchapter A, Chapter 1452; or

8 (B) receive, handle, or administer funds, if the
9 receipt, handling, or administration is directly or indirectly
10 related to a function regulated by this chapter, Chapter 843, 1271,
11 or 1367, or Subchapter A, Chapter 1452.

12 (4) "Delegation agreement" means an agreement by which
13 a health maintenance organization assigns the responsibility for a
14 function regulated by this chapter, Chapter 843, 1271, or 1367, or
15 Subchapter A, Chapter 1452.

16 (5) "Limited provider network" means a subnetwork
17 within a health maintenance organization delivery network in which
18 contractual relationships exist between physicians, certain
19 providers, independent physician associations, or physician groups
20 that limits an enrollee's access to physicians and providers to
21 those physicians and providers in the subnetwork.

22 (b) In this chapter, terms defined by Section 843.002 have
23 the meanings assigned by that section. (V.T.I.C. Art. 20A.02,
24 Secs. (dd), (ee), (ff), (gg), (hh); New.)

25 Sec. 1272.002. COMPLIANCE OF LIMITED PROVIDER NETWORK OR
26 DELEGATED ENTITY WITH CERTAIN LEGAL REQUIREMENTS. A limited
27 provider network or delegated entity shall comply with each

1 statutory or regulatory requirement that relates to a function
2 assumed by or carried out by the network or entity under this
3 chapter. (V.T.I.C. Art. 20A.18G.)

4 [Sections 1272.003-1272.050 reserved for expansion]

5 SUBCHAPTER B. DELEGATION AGREEMENTS

6 Sec. 1272.051. APPLICABILITY OF SUBCHAPTER. This
7 subchapter does not apply to a group model health maintenance
8 organization, as defined by Section 843.111. (V.T.I.C. Art.
9 20A.18C, Sec. (q).)

10 Sec. 1272.052. DELEGATION AGREEMENT REQUIRED. (a) A
11 health maintenance organization that delegates a function required
12 by this chapter, Chapter 843, 1271, or 1367, or Subchapter A,
13 Chapter 1452, shall execute a written delegation agreement with the
14 entity to which the function is delegated.

15 (b) The health maintenance organization shall file the
16 delegation agreement with the department not later than the 30th
17 day after the date the agreement is executed.

18 (c) The parties to the delegation agreement shall determine
19 which party bears the expense of complying with a requirement of
20 this subchapter, including the cost of an examination required by
21 the department under Article 1.15, if applicable. (V.T.I.C. Art.
22 20A.18C, Sec. (a) (part).)

23 Sec. 1272.053. MONITORING PLAN. A delegation agreement
24 required by Section 1272.052 must establish a monitoring plan that:

25 (1) allows the health maintenance organization to
26 monitor compliance with the minimum solvency requirements
27 established under Subchapter D, if applicable; and

1 (2) includes:

2 (A) a description of financial practices that
3 will ensure that the delegated entity tracks and reports
4 liabilities that have been incurred but not reported;

5 (B) a summary of the total amount paid by the
6 entity to physicians and providers on a monthly basis; and

7 (C) a summary of complaints from physicians,
8 providers, and enrollees regarding delays in payment or nonpayment
9 of claims, including the status of each complaint, on a monthly
10 basis. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

11 Sec. 1272.054. REQUIREMENTS FOR TERMINATION WITHOUT CAUSE.
12 A delegation agreement required by Section 1272.052 must provide
13 that the agreement cannot be terminated without cause by the
14 delegated entity or the health maintenance organization unless the
15 party terminating the agreement provides written notice before the
16 90th day before the termination date. (V.T.I.C. Art. 20A.18C, Sec.
17 (a) (part).)

18 Sec. 1272.055. COLLECTION OF PAYMENTS. A delegation
19 agreement required by Section 1272.052 must prohibit the delegated
20 entity and the physicians and providers with whom the entity has
21 contracted from billing or attempting to collect from an enrollee
22 under any circumstance, including the insolvency of the health
23 maintenance organization or entity, payments for covered services
24 other than authorized copayments and deductibles. (V.T.I.C. Art.
25 20A.18C, Sec. (a) (part).)

26 Sec. 1272.056. COMPLIANCE WITH STATUTORY AND REGULATORY
27 REQUIREMENTS. A delegation agreement required by Section 1272.052

1 must provide that:

2 (1) the agreement does not limit in any way the health
3 maintenance organization's authority or responsibility, including
4 financial responsibility, to comply with each statutory or
5 regulatory requirement; and

6 (2) the delegated entity shall comply with each
7 statutory or regulatory requirement relating to a function assumed
8 by or carried out by the entity. (V.T.I.C. Art. 20A.18C, Sec. (a)
9 (part).)

10 Sec. 1272.057. EXAMINATION BY COMMISSIONER. A delegation
11 agreement required by Section 1272.052 must require the delegated
12 entity to permit the commissioner to examine at any time any
13 information the commissioner reasonably believes is relevant to:

14 (1) the financial solvency of the entity; or

15 (2) the ability of the entity to meet the entity's
16 responsibilities in connection with any function delegated to the
17 entity by the health maintenance organization. (V.T.I.C. Art.
18 20A.18C, Sec. (a) (part).)

19 Sec. 1272.058. INFORMATION RELATING TO DELEGATED THIRD
20 PARTY. A delegation agreement required by Section 1272.052 must
21 require the delegated entity to provide the license number of a
22 delegated third party performing a function that requires:

23 (1) a license as a third-party administrator under
24 Chapter 4151 or utilization review agent under Article 21.58A; or

25 (2) another license under this code or another
26 insurance law of this state. (V.T.I.C. Art. 20A.18C, Sec. (a)
27 (part).)

1 Sec. 1272.059. CONTRACTS WITH DELEGATED THIRD PARTY. A
2 delegation agreement required by Section 1272.052 must provide
3 that:

4 (1) any agreement under which the delegated entity
5 directly or indirectly delegates a function required by this
6 chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452,
7 including the handling of funds, if applicable, to a delegated
8 third party must be in writing; and

9 (2) the delegated entity, in contracting with a
10 delegated third party directly or through a third party, shall
11 require the delegated third party to comply with the requirements
12 of Section 1272.057 and any rules adopted by the commissioner
13 implementing that section. (V.T.I.C. Art. 20A.18C, Sec. (a)
14 (part).)

15 Sec. 1272.060. UTILIZATION REVIEW. A delegation agreement
16 required by Section 1272.052 must provide that:

17 (1) enrollees shall receive notification at the time
18 of enrollment of which entity is responsible for performing
19 utilization review;

20 (2) the delegated entity or third party performing
21 utilization review shall perform that review in accordance with
22 Article 21.58A; and

23 (3) the delegated entity or third party shall forward
24 utilization review decisions made by the entity or third party to
25 the health maintenance organization on a monthly basis. (V.T.I.C.
26 Art. 20A.18C, Sec. (a) (part).)

27 Sec. 1272.061. RIGHTS AND DUTIES OF DELEGATED ENTITY AND

1 HEALTH MAINTENANCE ORGANIZATION. A delegation agreement required
2 by Section 1272.052 must provide that the delegated entity
3 acknowledges and agrees that:

4 (1) the health maintenance organization:

5 (A) is required to establish, operate, and
6 maintain a health care delivery system, quality assurance system,
7 provider credentialing system, and other systems and programs that
8 meet statutory and regulatory standards;

9 (B) is directly accountable for compliance with
10 those standards; and

11 (C) is not precluded from contractually
12 requesting that the delegated entity provide proof of financial
13 viability;

14 (2) the role of another delegated entity with which
15 the delegated entity subcontracts through a delegated third party
16 is limited to performing certain delegated functions of the health
17 maintenance organization, using standards that are approved by the
18 health maintenance organization and that are in compliance with
19 applicable statutes and rules and subject to the health maintenance
20 organization's oversight and monitoring of the entity's
21 performance; and

22 (3) if the delegated entity fails to meet monitoring
23 standards established to ensure that functions delegated or
24 assigned to the entity under the delegation agreement are in full
25 compliance with all statutory and regulatory requirements, the
26 health maintenance organization may cancel delegation of any or all
27 delegated functions. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

1 Sec. 1272.062. INFORMATION TO BE PROVIDED BY DELEGATED
2 ENTITY TO HEALTH MAINTENANCE ORGANIZATION. (a) A delegation
3 agreement required by Section 1272.052 must provide that:

4 (1) except as provided by Subsection (b), the
5 delegated entity shall make available to the health maintenance
6 organization samples of contracts with physicians and providers to
7 ensure compliance with the contractual requirements described by
8 Sections 1272.054 and 1272.055; and

9 (2) the delegated entity shall provide to the health
10 maintenance organization, in a format usable for audit purposes and
11 not more frequently than quarterly unless otherwise specified in
12 the delegation agreement, the data necessary for the health
13 maintenance organization to comply with the department's reporting
14 requirements with respect to any delegated functions performed
15 under the delegation agreement, including:

16 (A) a summary describing the methods, including
17 capitation, fee-for-service, or other risk arrangements, that the
18 delegated entity used to pay the entity's physicians and providers,
19 and including the percentage of physicians and providers paid for
20 each payment category;

21 (B) the period that claims and debts for medical
22 services owed by the delegated entity have been pending and the
23 aggregate dollar amount of those claims and debts;

24 (C) information to enable the health maintenance
25 organization to file claims for reinsurance, coordination of
26 benefits, and subrogation, if required by the delegation agreement;
27 and

1 (D) documentation, except for information,
2 documents, and deliberations related to peer review that are
3 confidential or privileged under Subchapter A, Chapter 160,
4 Occupations Code, that relates to:

5 (i) a regulatory agency's inquiry or
6 investigation of the delegated entity or an individual physician or
7 provider with whom the entity contracts that relates to an enrollee
8 of the health maintenance organization; and

9 (ii) the final resolution of a regulatory
10 agency's inquiry or investigation.

11 (b) A delegation agreement may not require a delegated
12 entity to make available to the health maintenance organization
13 contractual provisions relating to financial arrangements with the
14 entity's physicians and providers. (V.T.I.C. Art. 20A.18C, Sec.
15 (a) (part).)

16 Sec. 1272.063. ENROLLEE COMPLAINTS. (a) A delegation
17 agreement required by Section 1272.052 must provide that:

18 (1) if the delegated entity receives a complaint that
19 does not involve emergency care, the entity shall report the
20 complaint to the health maintenance organization not later than the
21 second business day after the date the entity receives the
22 complaint; and

23 (2) if the delegated entity receives a complaint
24 involving emergency care, the entity shall immediately forward the
25 complaint to the health maintenance organization.

26 (b) Subsection (a) does not prohibit a delegated entity from
27 attempting to resolve a complaint. (V.T.I.C. Art. 20A.18C, Sec.

1 (a) (part).)

2 Sec. 1272.064. RULES. The commissioner may adopt rules as
3 necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C,
4 Sec. (r).)

5 [Sections 1272.065-1272.100 reserved for expansion]

6 SUBCHAPTER C. INFORMATION REPORTING TO DELEGATED ENTITY

7 Sec. 1272.101. APPLICABILITY OF SUBCHAPTER. This
8 subchapter does not apply to a group model health maintenance
9 organization, as defined by Section 843.111. (V.T.I.C. Art.
10 20A.18C, Sec. (q).)

11 Sec. 1272.102. REPORTING REQUIRED. (a) The commissioner
12 shall determine the information a health maintenance organization
13 shall provide to a delegated entity with which the health
14 maintenance organization has entered into a delegation agreement.

15 (b) The information must include:

16 (1) for each enrollee who is eligible or assigned to
17 receive services from the delegated entity:

18 (A) the enrollee's name, birth date or social
19 security number, age, and sex;

20 (B) the benefit plan and any riders to that plan
21 that are applicable to the enrollee; and

22 (C) the enrollee's employer;

23 (2) the name and birth date or social security number
24 of each enrollee added or terminated since the health maintenance
25 organization last provided the information;

26 (3) if the health maintenance organization pays any
27 claims on behalf of the delegated entity, a summary of the number

1 and amount of:

2 (A) claims paid during the previous reporting
3 period; and

4 (B) pharmacy prescriptions paid for each
5 enrollee during the previous reporting period for which the
6 delegated entity has taken partial risk;

7 (4) information that enables the delegated entity to
8 file claims for reinsurance, coordination of benefits, and
9 subrogation;

10 (5) patient complaint data that relates to the
11 delegated entity;

12 (6) detailed risk-pool data, reported quarterly and on
13 settlement;

14 (7) if hospital or facility costs impact the delegated
15 entity's costs, the percent of premium attributable to hospital or
16 facility costs, reported quarterly; and

17 (8) if there are changes in hospital or facility
18 contracts with the health maintenance organization, the projected
19 impact of those changes on the percent of premium attributable to
20 hospital and facility costs during the 30-day period following
21 those changes.

22 (c) Notwithstanding Subsection (b)(3), a delegated entity
23 may, on request, receive additional nonproprietary information
24 regarding claims paid by a health maintenance organization on
25 behalf of the entity.

26 (d) A health maintenance organization shall provide
27 information required under Subsections (b)(1)-(5) in standard

1 electronic format at least monthly unless the delegation agreement
2 provides otherwise. (V.T.I.C. Art. 20A.18C, Secs. (b), (c).)

3 Sec. 1272.103. RULES. The commissioner may adopt rules as
4 necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C,
5 Sec. (r).)

6 [Sections 1272.104-1272.150 reserved for expansion]

7 SUBCHAPTER D. RESERVE REQUIREMENTS

8 Sec. 1272.151. APPLICABILITY OF SUBCHAPTER. This
9 subchapter does not apply to a group model health maintenance
10 organization, as defined by Section 843.111. (V.T.I.C. Art.
11 20A.18D, Sec. (h), as added Acts 77th Leg., R.S., Ch. 550.)

12 Sec. 1272.152. GENERAL RESERVE REQUIREMENTS. (a) A
13 delegated network shall maintain reserves adequate for the
14 liabilities and risks assumed by the network, as computed in
15 accordance with accepted standards, practices, and procedures
16 relating to the liabilities and risks for which the reserves are
17 maintained, including known and unknown components and anticipated
18 expenses of providing benefits or services.

19 (b) Except as provided by Sections 1272.153 and 1272.154, a
20 delegated network shall maintain reserves as described by
21 Subsection (c) only with respect to the portion of services assumed
22 under the delegation agreement that is outside the scope of the
23 network's license for medical care or hospital or other
24 institutional services, as applicable.

25 (c) A delegated network shall maintain financial reserves
26 equal to the greater of:

27 (1) 80 percent of the amount of liabilities and risks

1 for which reserves must be maintained under this subchapter and
2 that have been incurred but not paid by the network; or

3 (2) an amount equal to two months of the premium amount
4 assumed by the network for services with respect to which reserves
5 must be maintained under this subchapter. (V.T.I.C. Art. 20A.18D,
6 Secs. (a), (b), (e), as added Acts 77th Leg., R.S., Ch. 550.)

7 Sec. 1272.153. RESERVE REQUIREMENTS FOR MEDICAL CARE AND
8 HOSPITAL OR INSTITUTIONAL SERVICES. A delegated network that
9 assumes under a delegation agreement both medical care and hospital
10 or institutional services shall maintain reserves adequate to cover
11 the liabilities and risks associated with medical care or hospital
12 or institutional services, whichever category of services is
13 allocated the largest portion of the premium by the health
14 maintenance organization. (V.T.I.C. Art. 20A.18D, Sec. (c), as
15 added Acts 77th Leg., R.S., Ch. 550.)

16 Sec. 1272.154. RESERVE REQUIREMENTS FOR PRESCRIPTION
17 DRUGS. A delegated network that assumes financial risk for medical
18 care or hospital or institutional services and for prescription
19 drugs, as defined by Section 551.003, Occupations Code, shall
20 maintain, in addition to any other reserves required under this
21 subchapter, reserves adequate to cover the liabilities and risks
22 associated with the prescription drug benefits. (V.T.I.C. Art.
23 20A.18D, Sec. (d), as added Acts 77th Leg., R.S., Ch. 550.)

24 Sec. 1272.155. FORM OF RESERVES. The reserves required
25 under this subchapter must be:

26 (1) secured by and consist only of United States legal
27 tender or bonds of the United States or this state;

1 (2) held at a financial institution in this state that
2 is chartered by the United States or this state; and

3 (3) held in trust for, for the benefit of, or to
4 provide health care services to enrollees under the delegation
5 agreement. (V.T.I.C. Art. 20A.18D, Sec. (f), as added Acts 77th
6 Leg., R.S., Ch. 550.)

7 Sec. 1272.156. ESCROW ACCOUNT. (a) A delegated network
8 required to maintain reserves under this subchapter shall establish
9 an escrow account to pay claims and deposit the reserves into the
10 escrow account on:

11 (1) notification of the network's intent to terminate
12 or refuse to renew a contract under which the network assumed
13 liabilities and risks from a health maintenance organization; or

14 (2) modification of a contract under which the network
15 assumed liabilities and risks from a health maintenance
16 organization if the modified contract eliminates those liabilities
17 and risks.

18 (b) The delegated network shall notify the commissioner on
19 establishing an escrow account under this section.

20 (c) On the 271st day after the date the reserves are
21 deposited into the escrow account, the delegated network is
22 entitled to the release of funds remaining in escrow. Funds
23 released from the escrow account shall be distributed to each
24 individual who contributed to the reserves deposited into the
25 account in proportion to the individual's total contribution.

26 (d) The commissioner shall take any action necessary to
27 ensure the release of funds remaining in escrow after the date

1 specified by Subsection (c). (V.T.I.C. Art. 20A.18D, Sec. (g), as
2 added Acts 77th Leg., R.S., Ch. 550.)

3 [Sections 1272.157-1272.200 reserved for expansion]

4 SUBCHAPTER E. COMPLIANCE

5 Sec. 1272.201. APPLICABILITY OF SUBCHAPTER. This
6 subchapter does not apply to a group model health maintenance
7 organization, as defined by Section 843.111. (V.T.I.C. Art.
8 20A.18C, Sec. (q).)

9 Sec. 1272.202. NOTICE OF NONCOMPLIANCE OR HAZARDOUS
10 OPERATING CONDITION. (a) If a health maintenance organization
11 becomes aware of information that indicates a delegated entity with
12 which the health maintenance organization has entered into a
13 delegation agreement is not operating in accordance with the
14 agreement or is operating in a condition that renders continuing
15 the entity's business hazardous to the enrollees, the health
16 maintenance organization shall in writing:

17 (1) notify the entity of those findings; and

18 (2) request a written explanation and documentation
19 supporting that explanation of the entity's apparent noncompliance
20 or the existence of the hazardous condition.

21 (b) A health maintenance organization shall provide to the
22 commissioner a copy of each notice and request submitted to a
23 delegated entity under this section and each response or other
24 documentation the health maintenance organization receives or
25 generates in response to the notice and request. (V.T.I.C. Art.
26 20A.18C, Sec. (d).)

27 Sec. 1272.203. RESPONSE TO NOTICE. A delegated entity

1 shall respond in writing to a request from a health maintenance
2 organization under Section 1272.202 not later than the 30th day
3 after the date the entity receives the request. (V.T.I.C. Art.
4 20A.18C, Sec. (e).)

5 Sec. 1272.204. COOPERATION OF HEALTH MAINTENANCE
6 ORGANIZATION. A health maintenance organization shall cooperate
7 with a delegated entity to correct a failure by the entity to comply
8 with the department's regulatory requirements relating to:

9 (1) a function delegated to the entity by the health
10 maintenance organization; or

11 (2) a matter necessary for the health maintenance
12 organization to ensure compliance with each statutory or regulatory
13 requirement. (V.T.I.C. Art. 20A.18C, Sec. (f).)

14 Sec. 1272.205. EXAMINATION BY DEPARTMENT; REPORT. (a) On
15 receipt of a notice under Section 1272.202 or if complaints are
16 filed with the department, the department may conduct an
17 examination regarding:

18 (1) any matter contained in the notice; and

19 (2) any other matter relating to the financial
20 solvency of the delegated entity or the entity's ability to meet the
21 entity's responsibilities in connection with a function delegated
22 to the entity by the health maintenance organization.

23 (b) Except as provided by Subsection (c), the department, on
24 completion of an examination under this section, shall report to
25 the delegated entity and the health maintenance organization:

26 (1) the results of the examination; and

27 (2) any action the department determines is necessary

1 to ensure that:

2 (A) the health maintenance organization meets
3 the health maintenance organization's responsibilities under this
4 code, any other insurance laws of this state, and rules adopted by
5 the commissioner; and

6 (B) the entity is able to meet the entity's
7 responsibilities in connection with a function delegated to the
8 entity by the health maintenance organization.

9 (c) The department may not report to the health maintenance
10 organization information relating to fee schedules, prices, or cost
11 of care or other information not relevant to the monitoring plan.
12 (V.T.I.C. Art. 20A.18C, Secs. (g), (h).)

13 Sec. 1272.206. RESPONSE TO DEPARTMENT REPORT; CORRECTIVE
14 PLAN. The delegated entity and health maintenance organization
15 shall respond to the department's report under Section 1272.205(b)
16 and submit a corrective plan to the department not later than the
17 30th day after the date of receipt of the report. (V.T.I.C. Art.
18 20A.18C, Sec. (i).)

19 Sec. 1272.207. REQUEST FOR CORRECTIVE ACTION. The
20 department may request at any time that a delegated entity take
21 corrective action to comply with the department's statutory and
22 regulatory requirements that:

23 (1) relate to a function delegated by the health
24 maintenance organization to the entity; or

25 (2) are necessary to ensure the health maintenance
26 organization's compliance with each statutory or regulatory
27 requirement. (V.T.I.C. Art. 20A.18C, Sec. (k).)

1 Sec. 1272.208. AUTHORITY OF COMMISSIONER TO ISSUE ORDER.

2 (a) Regardless of whether a delegated entity complies with a
3 request for corrective action under Section 1272.207, the
4 commissioner may order a health maintenance organization with which
5 the entity has entered into a delegation agreement to take any
6 action the commissioner determines is necessary to ensure that the
7 health maintenance organization is complying with this chapter,
8 Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

9 (b) Actions the commissioner may order a health maintenance
10 organization to take under this section include:

11 (1) reassuming the functions delegated to the
12 delegated entity, including claims payments for services
13 previously provided to enrollees;

14 (2) temporarily or permanently ceasing assignment of
15 new enrollees to the entity;

16 (3) temporarily or permanently transferring enrollees
17 to alternative delivery systems to receive services; or

18 (4) terminating the delegation agreement with the
19 entity. (V.T.I.C. Art. 20A.18C, Sec. (l).)

20 Sec. 1272.209. PUBLIC DOCUMENTS. (a) Except as provided by
21 Subsection (b), a report required under Section 1272.205(b) or
22 corrective plan required under Section 1272.206 is a public
23 document.

24 (b) Health care provider fee schedules, prices, costs of
25 care, or other information that is not relevant to the monitoring
26 plan or is confidential by law is not a public document under this
27 section. (V.T.I.C. Art. 20A.18C, Sec. (j).)

1 Sec. 1272.210. RECORD OF COMPLAINTS; REPORT. (a) The
2 department shall:

3 (1) maintain enrollee and provider complaints in a
4 manner that identifies complaints made about limited provider
5 networks and delegated entities; and

6 (2) periodically issue a report on the complaints that
7 includes a list of complaints organized by:

8 (A) category;

9 (B) action taken on the complaint; and

10 (C) entity or network name and type.

11 (b) The department shall make available to the public the
12 report and information to assist the public in evaluating the
13 information contained in the report. (V.T.I.C. Art. 20A.18C, Sec.
14 (m).)

15 Sec. 1272.211. RULES. The commissioner may adopt rules as
16 necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C,
17 Sec. (r).)

18 [Sections 1272.212-1272.250 reserved for expansion]

19 SUBCHAPTER F. PENALTIES

20 Sec. 1272.251. APPLICABILITY OF SUBCHAPTER. This
21 subchapter does not apply to a group model health maintenance
22 organization, as defined by Section 843.111. (V.T.I.C. Art.
23 20A.18C, Sec. (q).)

24 Sec. 1272.252. SUSPENSION OR REVOCATION OF LICENSE OF
25 THIRD-PARTY ADMINISTRATOR OR UTILIZATION REVIEW AGENT.
26 Notwithstanding any other provision of this code or another
27 insurance law of this state, the commissioner may suspend or revoke

1 the license of a third-party administrator or utilization review
2 agent that fails to comply with Subchapter B, C, or E. (V.T.I.C.
3 Art. 20A.18C, Sec. (n).)

4 Sec. 1272.253. SANCTIONS AND PENALTIES AGAINST HEALTH
5 MAINTENANCE ORGANIZATION. The commissioner may impose sanctions or
6 penalties under Chapters 82, 83, and 84 on a health maintenance
7 organization that does not provide in a timely manner information
8 required by Subchapter C. (V.T.I.C. Art. 20A.18C, Sec. (o).)

9 Sec. 1272.254. CONTRACTUAL PENALTIES REQUIRED. A health
10 maintenance organization by contract shall establish penalties for
11 a delegated entity that does not provide in a timely manner
12 information required under a monitoring plan established under
13 Section 1272.053. (V.T.I.C. Art. 20A.18C, Sec. (p).)

14 Sec. 1272.255. RULES. The commissioner may adopt rules as
15 necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C,
16 Sec. (r).)

17 [Sections 1272.256-1272.300 reserved for expansion]

18 SUBCHAPTER G. PROVISION OF SERVICES BY LIMITED PROVIDER NETWORK
19 OR DELEGATED ENTITY

20 Sec. 1272.301. ACCESS TO OUT-OF-NETWORK SERVICES. (a) A
21 contract between a health maintenance organization and a limited
22 provider network or delegated entity must provide that:

23 (1) if medically necessary covered services are not
24 available through network physicians or providers, the limited
25 provider network or delegated entity, on the request of a network
26 physician or provider, shall:

27 (A) allow a referral to a non-network physician

1 or provider; and

2 (B) fully reimburse the non-network physician or
3 provider at the usual and customary rate or an agreed rate; and

4 (2) before the limited provider network or delegated
5 entity may deny a referral to a non-network physician or provider, a
6 specialist of the same or similar specialty as the type of physician
7 or provider to whom the referral is requested must conduct a review
8 of the request.

9 (b) The limited provider network or delegated entity shall
10 allow the referral within the time appropriate to the circumstances
11 relating to the delivery of the services and the condition of the
12 enrollee who is a patient, but not later than the fifth business day
13 after the date the network or entity receives any reasonably
14 requested documentation.

15 (c) An enrollee may not be required to change the enrollee's
16 primary care physician or specialist providers to receive medically
17 necessary covered services that are not available within the
18 limited provider network or through the delegated entity.

19 (d) A denial of out-of-network services under this section
20 is subject to appeal under Article 21.58A. (V.T.I.C. Art.
21 20A.18F.)

22 Sec. 1272.302. CONTINUITY OF CARE. (a) In this section,
23 "special circumstance" means a condition regarding which a treating
24 physician or provider reasonably believes that discontinuing care
25 by that physician or provider could cause harm to an enrollee who is
26 a patient. Examples of an enrollee who has a special circumstance
27 include an enrollee with a disability, acute condition, or

1 life-threatening illness and an enrollee who is past the 24th week
2 of pregnancy.

3 (b) A contract between a health maintenance organization
4 and a limited provider network or delegated entity must require
5 that each contract between the network or entity and a physician or
6 provider must:

7 (1) require that reasonable advance notice be given to
8 an enrollee of an impending termination from the network or entity
9 of a physician or provider who is currently treating the enrollee;
10 and

11 (2) provide that the termination of the physician's or
12 provider's contract, except for reason of medical competence or
13 professional behavior, does not release the network or entity from
14 the obligation to reimburse the physician or provider for treatment
15 of an enrollee who has a special circumstance at a rate that is not
16 less than the contract rate for that enrollee's care in exchange for
17 continuity of ongoing treatment of the enrollee then receiving
18 medically necessary treatment in accordance with the dictates of
19 medical prudence.

20 (c) The treating physician or provider shall identify a
21 special circumstance. That physician or provider must:

22 (1) request that the enrollee be permitted to continue
23 treatment under the physician's or provider's care; and

24 (2) agree not to seek payment from the enrollee who is
25 a patient of any amount for which the enrollee would not be
26 responsible if the physician or provider continued to be included
27 in the limited provider network or delegated entity.

(d) Except as provided by Subsection (e), this section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider for ongoing treatment of an enrollee after:

(1) the 90th day after the effective date of the termination; or

(2) if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.

(e) If an enrollee is past the 24th week of pregnancy at the time of termination, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee extends through delivery of the child, immediate postpartum care, and a follow-up checkup within the six-week period after delivery.

(f) A contract between a limited provider network or delegated entity and a physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider. (V.T.I.C. Art. 20A.18E.)

CHAPTER 1273. POINT-OF-SERVICE PLANS

SUBCHAPTER A. BLENDED CONTRACTS

Sec. 1273.001. DEFINITIONS

Sec. 1273.002. POINT-OF-SERVICE PLAN

Sec. 1273.003. BLENDED CONTRACT

Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING

PROVISIONS

1 Sec. 1273.005. RULES

2 [Sections 1273.006-1273.050 reserved for expansion]

3 SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS

4 Sec. 1273.051. DEFINITIONS

5 Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN

6 REQUIRED

7 Sec. 1273.053. COVERAGE OPTIONS

8 Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS

9 Sec. 1273.055. COST-SHARING PROVISIONS

10 Sec. 1273.056. EXCEPTIONS

11 Sec. 1273.057. RULES

12 CHAPTER 1273. POINT-OF-SERVICE PLANS

13 SUBCHAPTER A. BLENDED CONTRACTS

14 Sec. 1273.001. DEFINITIONS. In this subchapter:

15 (1) "Blended contract" means a single document,
16 including a single contract policy, certificate, or evidence of
17 coverage, that provides a combination of indemnity and health
18 maintenance organization benefits.

19 (2) "Health maintenance organization" has the meaning
20 assigned by Section 843.002.

21 (3) "Insurer" means an insurance company,
22 association, or organization authorized to engage in business in
23 this state under Chapter 841, 842, 861, 881, 882, 883, 884, 885,
24 886, 887, 888, 941, 942, or 982.

25 (4) "Point-of-service plan" means an arrangement
26 under which:

27 (A) an enrollee chooses to obtain benefits or

1 services through:

2 (i) a health maintenance organization
3 delivery network, including a limited provider network; or

4 (ii) a non-network delivery system outside
5 the health maintenance organization delivery network, including a
6 limited provider network, that is administered under an indemnity
7 benefit arrangement for the cost of health care services; or

8 (B) indemnity benefits for the cost of health
9 care services are provided by an insurer or group hospital service
10 corporation in conjunction with network benefits arranged or
11 provided by a health maintenance organization. (V.T.I.C. Art.
12 3.64, Sec. (a).)

13 Sec. 1273.002. POINT-OF-SERVICE PLAN. An insurer may
14 contract with a health maintenance organization to provide benefits
15 under a point-of-service plan, including optional coverage for
16 out-of-area services or out-of-network care. (V.T.I.C. Art. 3.64,
17 Sec. (b).)

18 Sec. 1273.003. BLENDED CONTRACT. (a) A health maintenance
19 organization and an insurer may offer a blended contract. The use
20 of a blended contract is limited to point-of-service arrangements
21 between a health maintenance organization and an insurer.

22 (b) A blended contract delivered, issued, or used in this
23 state is subject to, and must be filed with the department for
24 approval as provided by, Chapter 1701 and Section 1271.101.
25 (V.T.I.C. Art. 3.64, Secs. (c), (d).)

26 Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING
27 PROVISIONS. Indemnity benefits and services provided under a

1 point-of-service plan may be limited to those services described by
2 the blended contract and may be subject to different cost-sharing
3 provisions. The cost-sharing provisions for indemnity benefits may
4 be higher than the cost-sharing provisions for in-network health
5 maintenance organization coverage. For an enrollee in a limited
6 provider network, higher cost-sharing may be imposed only when the
7 enrollee obtains benefits or services outside the health
8 maintenance organization delivery network. (V.T.I.C. Art. 3.64,
9 Sec. (e).)

10 Sec. 1273.005. RULES. The commissioner may adopt rules to
11 implement this subchapter. (V.T.I.C. Art. 3.64, Sec. (f).)

12 [Sections 1273.006-1273.050 reserved for expansion]

13 SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS

14 Sec. 1273.051. DEFINITIONS. In this subchapter:

15 (1) "Employee" means an individual employed by an
16 employer.

17 (2) "Health benefit plan" has the meaning assigned by
18 Section 1501.002.

19 (3) "Non-network plan" means health benefit coverage
20 that provides an enrollee an opportunity to obtain health care
21 services through a health delivery system other than a health
22 maintenance organization delivery network, as defined by Section
23 843.002.

24 (4) "Point-of-service plan" means an arrangement
25 under which an enrollee chooses to obtain benefits or services
26 through:

27 (A) a health maintenance organization delivery

1 network, including a limited provider network; or

2 (B) a non-network delivery system outside the
3 health maintenance organization delivery network, including a
4 limited provider network, that is administered under an indemnity
5 benefit arrangement for the cost of health care services.

6 (5) "Preferred provider benefit plan" means an
7 insurance policy issued under Chapter 1301.

8 (6) "Small employer health benefit plan" has the
9 meaning assigned by Section 1501.002. (V.T.I.C. Art. 26.02,
10 Subdivs. (10), (11), (31), as amended Acts 77th Leg., R.S., Ch. 608,
11 (32), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.09, Sec.
12 (a).)

13 Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN
14 REQUIRED. (a) Except as provided by Subsection (b), if the only
15 health benefit coverage offered under an employer's health benefit
16 plan is a network-based delivery system of coverage offered by one
17 or more health maintenance organizations, each health maintenance
18 organization offering coverage must offer to all eligible
19 employees, at the time of enrollment and at least annually, the
20 opportunity to obtain coverage through a non-network plan.

21 (b) Each health maintenance organization to which
22 Subsection (a) applies may enter into an agreement designating one
23 or more of those health maintenance organizations to offer the
24 coverage required by Subsection (a) for eligible employees of the
25 employer. (V.T.I.C. Art. 26.09, Sec. (b) (part).)

26 Sec. 1273.053. COVERAGE OPTIONS. The coverage required to
27 be offered under this subchapter may be provided through:

- 1 (1) a point-of-service plan;
- 2 (2) a preferred provider benefit plan; or
- 3 (3) any coverage arrangement that provides an enrollee
- 4 with access to services outside the health maintenance
- 5 organization's or limited provider network's delivery network.
- 6 (V.T.I.C. Art. 26.09, Sec. (b) (part).)

7 Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS. The premium

8 for coverage required to be offered under this subchapter must be

9 based on the actuarial value of that coverage and may be different

10 from the premium for coverage otherwise offered by the health

11 maintenance organization. (V.T.I.C. Art. 26.09, Sec. (c).)

12 Sec. 1273.055. COST-SHARING PROVISIONS. (a) Different

13 cost-sharing provisions may be imposed for a point-of-service plan

14 offered under this subchapter, and those provisions may be higher

15 than the cost-sharing provisions for in-network health maintenance

16 organization coverage. For an enrollee in a limited provider

17 network, higher cost-sharing may be imposed only when the enrollee

18 obtains benefits or services outside the health maintenance

19 organization delivery network.

20 (b) An employee who chooses the non-network plan is

21 responsible for any additional costs for the non-network plan, and

22 the employer may impose a reasonable administrative fee for

23 providing the non-network plan. (V.T.I.C. Art. 26.09, Secs. (d),

24 (e).)

25 Sec. 1273.056. EXCEPTIONS. This subchapter does not apply

26 to:

- 27 (1) a small employer health benefit plan; or

1 (2) a group model health maintenance organization that
2 is a nonprofit, state-certified health maintenance organization
3 that:

4 (A) provides the majority of its professional
5 services through a single group medical practice that is governed
6 by a board composed entirely of physicians; and

7 (B) educates medical students or resident
8 physicians through a contract with the medical school component of
9 a Texas state-supported college or university accredited by the
10 Accreditation Council on Graduate Medical Education or the American
11 Osteopathic Association. (V.T.I.C. Art. 26.09, Sec. (f).)

12 Sec. 1273.057. RULES. The commissioner shall adopt rules
13 necessary to administer this subchapter. (V.T.I.C. Art. 26.04
14 (part).)

15 [Chapters 1274-1300 reserved for expansion]

16 SUBTITLE D. PREFERRED PROVIDER BENEFIT PLANS

17 CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

18 SUBCHAPTER A. GENERAL PROVISIONS

19 Sec. 1301.001. DEFINITIONS

20 Sec. 1301.002. NONAPPLICABILITY TO DENTAL CARE BENEFITS

21 Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS PERMITTED

22 Sec. 1301.004. COMPLIANCE WITH CHAPTER REQUIRED

23 Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS

24 Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH

25 CARE SERVICES

26 Sec. 1301.007. RULES

27 [Sections 1301.008-1301.050 reserved for expansion]

SUBCHAPTER B. RELATIONS WITH PHYSICIANS OR HEALTH CARE PROVIDERS

Sec. 1301.051. DESIGNATION AS PREFERRED PROVIDER

Sec. 1301.052. DESIGNATION OF ADVANCED PRACTICE NURSE OR
PHYSICIAN ASSISTANT AS PREFERRED PROVIDER

Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED
PROVIDER

Sec. 1301.054. NOTICE TO PRACTITIONERS OF PREFERRED PROVIDER
BENEFIT PLAN

Sec. 1301.055. COMPLAINT RESOLUTION

Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT

Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED REVIEW
PROCESS

Sec. 1301.058. ECONOMIC PROFILING

Sec. 1301.059. QUALITY ASSESSMENT

Sec. 1301.060. COMPENSATION ON DISCOUNTED FEE BASIS

Sec. 1301.061. PREFERRED PROVIDER NETWORKS

Sec. 1301.062. PREFERRED PROVIDER CONTRACTS BETWEEN INSURERS
AND PODIATRISTS

Sec. 1301.063. CONTRACT PROVISIONS RELATING TO USE OF
HOSPITALIST

Sec. 1301.064. CONTRACT PROVISIONS RELATING TO PAYMENT OF
CLAIMS

Sec. 1301.065. SHIFTING OF INSURER'S TORT LIABILITY
PROHIBITED

Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER
PROHIBITED

Sec. 1301.067. INTERFERENCE WITH RELATIONSHIP BETWEEN

PATIENT AND PHYSICIAN OR HEALTH CARE

PROVIDER PROHIBITED

Sec. 1301.068. INDUCEMENT TO LIMIT MEDICALLY NECESSARY

SERVICES PROHIBITED

[Sections 1301.069-1301.100 reserved for expansion]

SUBCHAPTER C. PAYMENT OF CLAIMS TO PROVIDERS

Sec. 1301.101. DEFINITION

Sec. 1301.102. ACKNOWLEDGMENT OF RECEIPT OF CLAIM

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS

Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION

BENEFIT CLAIMS

Sec. 1301.105. AUDITED CLAIMS

Sec. 1301.106. CLAIMS PROCESSING PROCEDURES

Sec. 1301.107. VIOLATION OF CLAIMS PAYMENT PROVISIONS;

ADMINISTRATIVE PENALTY

Sec. 1301.108. ATTORNEY'S FEES

Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH

INSURER

Sec. 1301.110. EXCEPTION

[Sections 1301.111-1301.150 reserved for expansion]

SUBCHAPTER D. RELATIONS BETWEEN INSURED'S

AND PREFERRED PROVIDERS

Sec. 1301.151. INSURED'S RIGHT TO TREATMENT

Sec. 1301.152. CONTINUING CARE IN GENERAL

Sec. 1301.153. CONTINUITY OF CARE

Sec. 1301.154. OBLIGATION FOR CONTINUITY OF CARE OF

INSURER

1 Sec. 1301.155. EMERGENCY CARE

2 Sec. 1301.156. PAYMENT OF CLAIMS TO INSURED

3 Sec. 1301.157. PLAIN LANGUAGE REQUIREMENTS

4 Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER

5 BENEFIT PLANS

6 Sec. 1301.159. ANNUAL LIST OF PREFERRED PROVIDERS

7 Sec. 1301.160. NOTIFICATION OF TERMINATION OF PARTICIPATION

8 OF PREFERRED PROVIDER

9 Sec. 1301.161. RETALIATION AGAINST INSURED PROHIBITED

10 [Sections 1301.162-1301.200 reserved for expansion]

11 SUBCHAPTER E. CERTAIN HEALTH CARE PROVIDERS

12 Sec. 1301.201. CONTRACTS WITH AND REIMBURSEMENT FOR NURSE

13 FIRST ASSISTANTS

14 CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

15 SUBCHAPTER A. GENERAL PROVISIONS

16 Sec. 1301.001. DEFINITIONS. In this chapter:

17 (1) "Health care provider" means a practitioner,
18 institutional provider, or other person or organization that
19 furnishes health care services and that is licensed or otherwise
20 authorized to practice in this state. The term does not include a
21 physician.

22 (2) "Health insurance policy" means a group or
23 individual insurance policy, certificate, or contract providing
24 benefits for medical or surgical expenses incurred as a result of an
25 accident or sickness.

26 (3) "Hospital" means a licensed public or private
27 institution as defined by Chapter 241, Health and Safety Code, or

1 Subtitle C, Title 7, Health and Safety Code.

2 (4) "Institutional provider" means a hospital,
3 nursing home, or other medical or health-related service facility
4 that provides care for the sick or injured or other care that may be
5 covered in a health insurance policy.

6 (5) "Insurer" means a life, health, and accident
7 insurance company, health and accident insurance company, health
8 insurance company, or other company operating under Chapter 841,
9 842, 884, 885, 982, or 1501, that is authorized to issue, deliver,
10 or issue for delivery in this state health insurance policies.

11 (6) "Physician" means a person licensed to practice
12 medicine in this state.

13 (7) "Practitioner" means a person who practices a
14 healing art and is a practitioner described by Section 1451.001 or
15 1451.101.

16 (8) "Preferred provider" means a physician or health
17 care provider, or an organization of physicians or health care
18 providers, who contracts with an insurer to provide medical care or
19 health care to insureds covered by a health insurance policy.

20 (9) "Preferred provider benefit plan" means a benefit
21 plan in which an insurer provides, through its health insurance
22 policy, for the payment of a level of coverage that is different
23 from the basic level of coverage provided by the health insurance
24 policy if the insured person uses a preferred provider.

25 (10) "Service area" means a geographic area or areas
26 specified in a health insurance policy or preferred provider
27 contract in which a network of preferred providers is offered and

1 available. (V.T.I.C. Art. 3.70-3C, Secs. 1(2), (3), (4), (5), (6),
2 (8), (9), (10), (13), 2 (part), as added Acts 75th Leg., R.S., Ch.
3 1024; Art. 3.70-3C, Sec. 1, as added Acts 75th Leg., R.S., Ch.
4 1260.)

5 Sec. 1301.002. NONAPPLICABILITY TO DENTAL CARE BENEFITS.
6 This chapter does not apply to a provision for dental care benefits
7 in a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 2
8 (part), as added Acts 75th Leg., R.S., Ch. 1024.)

9 Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS PERMITTED.
10 A health insurance policy that provides different benefits from the
11 basic level of coverage for the use of preferred providers and that
12 meets the requirements of this chapter is not:

- 13 (1) unjust under Chapter 1701;
14 (2) unfair discrimination under Subchapter A or B,
15 Chapter 544; or
16 (3) a violation of Subchapter B or C, Chapter 1451.
17 (V.T.I.C. Art. 3.70-3C, Sec. 3(a), as added Acts 75th Leg., R.S.,
18 Ch. 1024.)

19 Sec. 1301.004. COMPLIANCE WITH CHAPTER REQUIRED. Each
20 preferred provider benefit plan offered in this state must comply
21 with this chapter. (V.T.I.C. Art. 3.70-3C, Sec. 3(1) (part), as
22 added Acts 75th Leg., R.S., Ch. 1024.)

23 Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS. (a)
24 An insurer offering a preferred provider benefit plan shall ensure
25 that both preferred provider benefits and basic level benefits are
26 reasonably available to all insureds within a designated service
27 area.

1 (b) If services are not available through a preferred
2 provider within the service area, an insurer shall reimburse a
3 physician or health care provider who is not a preferred provider at
4 the same percentage level of reimbursement as a preferred provider
5 would have been reimbursed had the insured been treated by a
6 preferred provider.

7 (c) Subsection (b) does not require reimbursement at a
8 preferred level of coverage solely because an insured resides out
9 of the service area and chooses to receive services from a provider
10 other than a preferred provider for the insured's own convenience.
11 (V.T.I.C. Art. 3.70-3C, Sec. 8, as added Acts 75th Leg., R.S., Ch.
12 1024.)

13 Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH
14 CARE SERVICES. An insurer that markets a preferred provider
15 benefit plan shall contract with physicians and health care
16 providers to ensure that all medical and health care services and
17 items contained in the package of benefits for which coverage is
18 provided, including treatment of illnesses and injuries, will be
19 provided under the health insurance policy in a manner ensuring
20 availability of and accessibility to adequate personnel, specialty
21 care, and facilities. (V.T.I.C. Art. 3.70-3C, Sec. 3(d), as added
22 Acts 75th Leg., R.S., Ch. 1024.)

23 Sec. 1301.007. RULES. The commissioner shall adopt rules
24 as necessary to:

- 25 (1) implement this chapter; and
26 (2) ensure reasonable accessibility and availability
27 of preferred provider benefits and basic level benefits to

1 residents of this state. (V.T.I.C. Art. 3.70-3C, Sec. 9, as added
2 Acts 75th Leg., R.S., Ch. 1024.)

3 [Sections 1301.008-1301.050 reserved for expansion]

4 SUBCHAPTER B. RELATIONS WITH PHYSICIANS OR HEALTH CARE PROVIDERS

5 Sec. 1301.051. DESIGNATION AS PREFERRED PROVIDER. (a) An
6 insurer shall afford a fair, reasonable, and equivalent opportunity
7 to apply to be and to be designated as a preferred provider to
8 practitioners and institutional providers and to health care
9 providers other than practitioners and institutional providers, if
10 those other health care providers are included by the insurer as
11 preferred providers, provided that the practitioners,
12 institutional providers, or health care providers:

13 (1) are licensed to treat injuries or illnesses or to
14 provide services covered by a health insurance policy; and

15 (2) comply with the terms established by the insurer
16 for designation as preferred providers.

17 (b) An insurer may not unreasonably withhold a designation
18 as a preferred provider.

19 (c) An insurer shall give a physician or health care
20 provider who, on the person's initial application, is not
21 designated as a preferred provider written reasons for denial of
22 the designation.

23 (d) Unless otherwise limited by this code, this section does
24 not prohibit an insurer from rejecting a physician's or health care
25 provider's application for designation based on a determination
26 that the preferred provider benefit plan has sufficient qualified
27 providers. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(1), (4), as added

1 Acts 75th Leg., R.S., Ch. 1024.)

2 Sec. 1301.052. DESIGNATION OF ADVANCED PRACTICE NURSE OR
3 PHYSICIAN ASSISTANT AS PREFERRED PROVIDER. An insurer offering a
4 preferred provider benefit plan may not refuse a request made by a
5 physician participating as a preferred provider under the plan and
6 an advanced practice nurse or physician assistant to have the
7 advanced practice nurse or physician assistant included as a
8 preferred provider under the plan if:

9 (1) the advanced practice nurse or physician assistant
10 is authorized by the physician to provide care under Subchapter B,
11 Chapter 157, Occupations Code; and

12 (2) the advanced practice nurse or physician assistant
13 meets the quality of care standards previously established by the
14 insurer for participation in the plan by advanced practice nurses
15 and physician assistants. (V.T.I.C. Art. 3.70-3C, Sec. 2, as added
16 Acts 75th Leg., R.S., Ch. 1260.)

17 Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED
18 PROVIDER. (a) An insurer that does not designate a practitioner as
19 a preferred provider shall provide a reasonable mechanism for
20 reviewing that action. The review mechanism must incorporate, in
21 an advisory role only, a review panel.

22 (b) A review panel must be composed of at least three
23 individuals selected by the insurer from a list of participating
24 practitioners and must include one member who is a practitioner in
25 the same or similar specialty as the affected practitioner, if
26 available. The practitioners contracting with the insurer in the
27 applicable service area shall provide the list of practitioners to

1 the insurer.

2 (c) On request, the insurer shall provide to the affected
3 practitioner:

4 (1) the panel's recommendation, if any; and

5 (2) a written explanation of the insurer's
6 determination, if that determination is contrary to the panel's
7 recommendation. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(2), (3), as
8 added Acts 75th Leg., R.S., Ch. 1024.)

9 Sec. 1301.054. NOTICE TO PRACTITIONERS OF PREFERRED
10 PROVIDER BENEFIT PLAN. (a) When sponsoring a preferred provider
11 benefit plan, an insurer shall immediately notify each practitioner
12 in the plan's service area of the insurer's intent to offer the plan
13 and of the opportunity to participate. The notification must be
14 made by publication or in writing to each practitioner.

15 (b) After establishing a preferred provider benefit plan,
16 an insurer shall annually provide notice of and an opportunity to
17 participate in the plan to practitioners in the plan's service area
18 who do not participate in the plan.

19 (c) On request, an insurer shall provide to any physician or
20 health care provider information concerning the application
21 process and qualification requirements for participation as a
22 preferred provider in the plan. (V.T.I.C. Art. 3.70-3C, Sec. 3(c),
23 as added Acts 75th Leg., R.S., Ch. 1024.)

24 Sec. 1301.055. COMPLAINT RESOLUTION. (a) Each contract
25 under a preferred provider benefit plan between an insurer and a
26 physician or other practitioner or a physicians' group must have a
27 mechanism for resolving complaints initiated by an insured, a

1 physician or other practitioner, or a physicians' group.

2 (b) A complaint resolution mechanism must provide for
3 reasonable due process that includes, in an advisory role only, a
4 review panel selected in the manner described by Section
5 1301.053(b). (V.T.I.C. Art. 3.70-3C, Sec. 3(f), as added Acts 75th
6 Leg., R.S., Ch. 1024.)

7 Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT.

8 (a) An insurer or third-party administrator may not reimburse a
9 physician or other practitioner, institutional provider, or
10 organization of physicians and health care providers on a
11 discounted fee basis for covered services that are provided to an
12 insured unless:

13 (1) the insurer or third-party administrator has
14 contracted with either:

15 (A) the physician or other practitioner,
16 institutional provider, or organization of physicians and health
17 care providers; or

18 (B) a preferred provider organization that has a
19 network of preferred providers and that has contracted with the
20 physician or other practitioner, institutional provider, or
21 organization of physicians and health care providers;

22 (2) the physician or other practitioner,
23 institutional provider, or organization of physicians and health
24 care providers has agreed to the contract and has agreed to provide
25 health care services under the terms of the contract; and

26 (3) the insurer or third-party administrator has
27 agreed to provide coverage for those health care services under the

1 health insurance policy.

2 (b) A party to a preferred provider contract, including a
3 contract with a preferred provider organization, may not sell,
4 lease, or otherwise transfer information regarding the payment or
5 reimbursement terms of the contract without the express authority
6 of and prior adequate notification to the other contracting
7 parties. This subsection does not affect the authority of the
8 commissioner or the Texas Workers' Compensation Commission under
9 this code to request and obtain information.

10 (c) An insurer or third-party administrator who violates
11 this section:

12 (1) commits an unfair claim settlement practice in
13 violation of Subchapter A, Chapter 542; and

14 (2) is subject to administrative penalties under
15 Chapters 82 and 84. (V.T.I.C. Art. 3.70-3C, Sec. 7A, as added Acts
16 75th Leg., R.S., Ch. 1024.)

17 Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED
18 REVIEW PROCESS. (a) Before terminating a contract with a preferred
19 provider, an insurer shall:

20 (1) provide written reasons for the termination; and

21 (2) if the affected provider is a practitioner,
22 provide, on request, a reasonable review mechanism, except in a
23 case involving:

24 (A) imminent harm to a patient's health;

25 (B) an action by a state medical or other
26 physician licensing board or other government agency that
27 effectively impairs the practitioner's ability to practice

1 medicine; or

2 (C) fraud or malfeasance.

3 (b) The review mechanism described by Subsection (a)(2)
4 must incorporate, in an advisory role only, a review panel selected
5 in the manner described by Section 1301.053(b) and must be
6 completed within a period not to exceed 60 days.

7 (c) The insurer shall provide to the affected practitioner:

8 (1) the panel's recommendation, if any; and

9 (2) on request, a written explanation of the insurer's
10 determination, if that determination is contrary to the panel's
11 recommendation.

12 (d) On request, an insurer shall make an expedited review
13 available to a practitioner whose participation in a preferred
14 provider benefit plan is being terminated. The expedited review
15 process must comply with rules established by the commissioner.
16 (V.T.I.C. Art. 3.70-3C, Sec. 3(g), as added Acts 75th Leg., R.S.,
17 Ch. 1024.)

18 Sec. 1301.058. ECONOMIC PROFILING. An insurer that
19 conducts, uses, or relies on economic profiling to admit or
20 terminate the participation of physicians or health care providers
21 in a preferred provider benefit plan shall make available to a
22 physician or health care provider on request the economic profile
23 of that physician or health care provider, including the written
24 criteria by which the physician or health care provider's
25 performance is to be measured. An economic profile must be adjusted
26 to recognize the characteristics of a physician's or health care
27 provider's practice that may account for variations from expected

costs. (V.T.I.C. Art. 3.70-3C, Sec. 3(h), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.059. QUALITY ASSESSMENT. (a) In this section, "quality assessment" means a mechanism used by an insurer to evaluate, monitor, or improve the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with the care delivered by an ordinary, reasonable, and prudent physician or health care provider under the same or similar circumstances.

(b) An insurer may not engage in quality assessment except through a panel of at least three physicians selected by the insurer from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer. (V.T.I.C. Art. 3.70-3C, Secs. 1(12), 3(i), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.060. COMPENSATION ON DISCOUNTED FEE BASIS. A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge. (V.T.I.C. Art. 3.70-3C, Sec. 3(k), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.061. PREFERRED PROVIDER NETWORKS. (a) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred

1 providers. The agreement may provide that either the insurer or the
2 preferred provider organization on the insurer's behalf will comply
3 with the notice requirements and other requirements imposed on the
4 insurer by this subchapter.

5 (b) An insurer that enters into an agreement with a
6 preferred provider organization under this section shall meet the
7 requirements of this chapter or ensure that those requirements are
8 met. (V.T.I.C. Art. 3.70-3C, Sec. 3(1) (part), as added Acts 75th
9 Leg., R.S., Ch. 1024.)

10 Sec. 1301.062. PREFERRED PROVIDER CONTRACTS BETWEEN
11 INSURERS AND PODIATRISTS. A preferred provider contract between an
12 insurer and a podiatrist licensed by the Texas State Board of
13 Podiatric Medical Examiners must provide that:

14 (1) the podiatrist may request a copy of the coding
15 guidelines and payment schedules applicable to the compensation
16 that the podiatrist will receive under the contract for services;

17 (2) the insurer shall provide a copy of the coding
18 guidelines and payment schedules not later than the 30th day after
19 the date of the podiatrist's request;

20 (3) the insurer may not unilaterally make material
21 retroactive revisions to the coding guidelines and payment
22 schedules; and

23 (4) the podiatrist may, practicing within the scope of
24 the law regulating podiatry, furnish x-rays and nonprefabricated
25 orthotics covered by the health insurance policy. (V.T.I.C. Art.
26 3.70-3C, Sec. 3(n), as added Acts 75th Leg., R.S., Ch. 1024.)

27 Sec. 1301.063. CONTRACT PROVISIONS RELATING TO USE OF

1 HOSPITALIST. (a) In this section, "hospitalist" means a physician
2 who:

3 (1) serves as physician of record at a hospital for a
4 hospitalized patient of another physician; and

5 (2) returns the care of the patient to that other
6 physician at the end of the patient's hospitalization.

7 (b) A preferred provider contract between an insurer and a
8 physician may not require the physician to use a hospitalist for a
9 hospitalized patient. (V.T.I.C. Art. 3.70-3C, Sec. 3B, as added
10 Acts 75th Leg., R.S., Ch. 1024.)

11 Sec. 1301.064. CONTRACT PROVISIONS RELATING TO PAYMENT OF
12 CLAIMS. Subject to Subchapter C, a preferred provider contract
13 must provide for payment to a physician or health care provider for
14 health care services and benefits provided to an insured under the
15 contract and to which the insured is entitled under the terms of the
16 contract not later than:

17 (1) the 45th day after the date on which a claim for
18 payment is received with the documentation reasonably necessary to
19 process the claim; or

20 (2) if applicable, within the number of calendar days
21 specified by written agreement between the physician or health care
22 provider and the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 3(m)
23 (part), as added Acts 75th Leg., R.S., Ch. 1024.)

24 Sec. 1301.065. SHIFTING OF INSURER'S TORT LIABILITY
25 PROHIBITED. A preferred provider contract may not require any
26 physician, health care provider, or physicians' group to execute a
27 hold harmless clause to shift the insurer's tort liability

1 resulting from the insurer's acts or omissions to the preferred
2 provider. (V.T.I.C. Art. 3.70-3C, Sec. 3(j), as added Acts 75th
3 Leg., R.S., Ch. 1024.)

4 Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER
5 PROHIBITED. An insurer may not engage in any retaliatory action
6 against a physician or health care provider, including terminating
7 the physician's or provider's participation in the preferred
8 provider benefit plan or refusing to renew the physician's or
9 provider's contract, because the physician or provider has:

10 (1) on behalf of an insured, reasonably filed a
11 complaint against the insurer; or

12 (2) appealed a decision of the insurer. (V.T.I.C.
13 Art. 3.70-3C, Sec. 7(b), as added Acts 75th Leg., R.S., Ch. 1024.)

14 Sec. 1301.067. INTERFERENCE WITH RELATIONSHIP BETWEEN
15 PATIENT AND PHYSICIAN OR HEALTH CARE PROVIDER PROHIBITED. (a) An
16 insurer may not, as a condition of a preferred provider contract
17 with a physician or health care provider or in any other manner,
18 prohibit, attempt to prohibit, or discourage a physician or
19 provider from discussing with or communicating to a current,
20 prospective, or former patient, or a person designated by a
21 patient, information or an opinion:

22 (1) regarding the patient's health care, including the
23 patient's medical condition or treatment options; or

24 (2) in good faith regarding the provisions, terms,
25 requirements, or services of the health insurance policy as they
26 relate to the patient's medical needs.

27 (b) An insurer may not in any way penalize, terminate the

1 participation of, or refuse to compensate for covered services a
2 physician or health care provider for discussing or communicating
3 with a current, prospective, or former patient, or a person
4 designated by a patient, pursuant to this section. (V.T.I.C. Art.
5 3.70-3C, Sec. 7(c), as added Acts 75th Leg., R.S., Ch. 1024.)

6 Sec. 1301.068. INDUCEMENT TO LIMIT MEDICALLY NECESSARY
7 SERVICES PROHIBITED. (a) An insurer may not use any financial
8 incentive or make payment to a physician or health care provider
9 that acts directly or indirectly as an inducement to limit
10 medically necessary services.

11 (b) This section does not prohibit the use of capitation as
12 a method of payment. (V.T.I.C. Art. 3.70-3C, Sec. 7(d), as added
13 Acts 75th Leg., R.S., Ch. 1024.)

14 [Sections 1301.069-1301.100 reserved for expansion]

15 SUBCHAPTER C. PAYMENT OF CLAIMS TO PROVIDERS

16 Sec. 1301.101. DEFINITION. In this subchapter, "clean
17 claim" means a completed claim, as determined under department
18 rules, submitted by a preferred provider for medical care or health
19 care services under a health insurance policy. (V.T.I.C. Art.
20 3.70-3C, Sec. 3A(a), as added Acts 75th Leg., R.S., Ch. 1024.)

21 Sec. 1301.102. ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A
22 preferred provider may obtain acknowledgment of receipt of a claim
23 for medical care or health care services under a health insurance
24 policy by submitting the claim by United States mail, return
25 receipt requested.

26 (b) An insurer or the contracted clearinghouse of an insurer
27 that receives a claim electronically shall acknowledge receipt of

1 the claim by an electronic transmission to the preferred provider
2 and is not required to acknowledge receipt of the claim in writing.
3 (V.T.I.C. Art. 3.70-3C, Sec. 3A(b), as added Acts 75th Leg., R.S.,
4 Ch. 1024.)

5 Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Not
6 later than the 45th day after the date on which an insurer receives
7 a clean claim from a preferred provider, the insurer shall:

8 (1) pay the total amount of the claim in accordance
9 with the contract between the preferred provider and the insurer;

10 (2) pay the portion of the claim that is not in dispute
11 and notify the preferred provider in writing why the remaining
12 portion of the claim will not be paid; or

13 (3) notify the preferred provider in writing why the
14 claim will not be paid. (V.T.I.C. Art. 3.70-3C, Sec. 3A(c), as
15 added Acts 75th Leg., R.S., Ch. 1024.)

16 Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION
17 BENEFIT CLAIMS. If a preferred provider or its designated agent
18 authorizes treatment, a prescription benefit claim that is
19 electronically adjudicated and electronically paid shall be paid
20 not later than the 21st day after the date on which the treatment is
21 authorized. (V.T.I.C. Art. 3.70-3C, Sec. 3A(d), as added Acts 75th
22 Leg., R.S., Ch. 1024.)

23 Sec. 1301.105. AUDITED CLAIMS. An insurer that
24 acknowledges coverage of an insured under a health insurance policy
25 but intends to audit a claim submitted by a preferred provider shall
26 pay the charges submitted at 85 percent of the contracted rate on
27 the claim not later than the 45th day after the date on which the

insurer receives the claim from the preferred provider. Following completion of the audit, any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the later of the date that:

(1) the preferred provider receives notice of the audit results; or

(2) any appeal rights of the insured are exhausted. (V.T.I.C. Art. 3.70-3C, Sec. 3A(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.106. CLAIMS PROCESSING PROCEDURES. (a) An insurer shall provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures, including required data elements and claim formats.

(b) An insurer may, by contract with a preferred provider, add or change the data elements that must be submitted with a claim.

(c) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in an insurer's claim processing and payment procedures, the insurer shall provide written notice of the addition or change to each preferred provider. (V.T.I.C. Art. 3.70-3C, Secs. 3A(i), (j), (k), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.107. VIOLATION OF CLAIMS PAYMENT PROVISIONS; ADMINISTRATIVE PENALTY. (a) An insurer that violates Section 1301.103 or 1301.105 is liable to a preferred provider for the full amount of billed charges submitted on the claim or the amount

1 payable under the contracted penalty rate, less any amount
2 previously paid or any charge for a service that is not covered by
3 the health insurance policy.

4 (b) In addition to any other penalty or remedy authorized by
5 this code or another insurance law of this state, an insurer that
6 violates Section 1301.103 or 1301.105 is subject to an
7 administrative penalty under Chapter 84. The administrative
8 penalty imposed under that chapter may not exceed \$1,000 for each
9 day the claim remains unpaid in violation of Section 1301.103 or
10 1301.105. (V.T.I.C. Art. 3.70-3C, Secs. 3A(f), (h), as added Acts
11 75th Leg., R.S., Ch. 1024.)

12 Sec. 1301.108. ATTORNEY'S FEES. A preferred provider may
13 recover reasonable attorney's fees in an action to recover payment
14 under this subchapter. (V.T.I.C. Art. 3.70-3C, Sec. 3A(g), as
15 added Acts 75th Leg., R.S., Ch. 1024.)

16 Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH
17 INSURER. This subchapter applies to a person with whom an insurer
18 contracts to:

19 (1) process claims; or

20 (2) obtain the services of a preferred provider to
21 provide medical care or health care to an insured under a health
22 insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(m), as added
23 Acts 75th Leg., R.S., Ch. 1024.)

24 Sec. 1301.110. EXCEPTION. This subchapter does not apply
25 to a claim submitted by a preferred provider who is a member of the
26 legislature. (V.T.I.C. Art. 3.70-3C, Sec. 3A(l), as added Acts
27 75th Leg., R.S., Ch. 1024.)

[Sections 1301.111-1301.150 reserved for expansion]

SUBCHAPTER D. RELATIONS BETWEEN INSURED

AND PREFERRED PROVIDERS

Sec. 1301.151. INSURED'S RIGHT TO TREATMENT. Each insured is entitled to treatment and diagnostic techniques that are prescribed by the physician or health care provider included in the preferred provider benefit plan. (V.T.I.C. Art. 3.70-3C, Sec. 3(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.152. CONTINUING CARE IN GENERAL. (a) An insurer shall establish reasonable procedures for ensuring a transition of insureds to physicians or health care providers and for continuity of treatment.

(b) An insurer shall:

(1) provide, subject to Section 1301.160, reasonable advance notice to an insured of the impending termination of the participation in the plan of a physician or health care provider who is currently treating the insured; and

(2) in the event of termination of a preferred provider's participation in the plan, make available to the insured a current listing of preferred providers.

(c) A contract between an insurer and a physician or health care provider must include a procedure for resolving disputes regarding the necessity for continued treatment by the physician or provider. (V.T.I.C. Art. 3.70-3C, Secs. 4(a), (d), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.153. CONTINUITY OF CARE. (a) In this section:

(1) "Life-threatening" means a disease or condition

1 for which the likelihood of death is probable unless the course of
2 the disease or condition is interrupted.

3 (2) "Special circumstances" means a condition
4 regarding which the treating physician or health care provider
5 reasonably believes that discontinuing care by the treating
6 physician or provider could cause harm to the insured. Examples of
7 an insured who has a special circumstance include an insured with a
8 disability, acute condition, or life-threatening illness or an
9 insured who is past the 24th week of pregnancy.

10 (b) Each contract between an insurer and a physician or
11 health care provider must provide that the termination of the
12 physician's or provider's participation in a preferred provider
13 benefit plan, except for reason of medical competence or
14 professional behavior, does not:

15 (1) release the physician or health care provider from
16 the generally recognized obligation to:

17 (A) treat an insured whom the physician or
18 provider is currently treating; and

19 (B) cooperate in arranging for appropriate
20 referrals; or

21 (2) release the insurer from the obligation to
22 reimburse the physician or health care provider or, if applicable,
23 the insured, at the same preferred provider rate if, at the time a
24 physician's or provider's participation is terminated, an insured
25 whom the physician or provider is currently treating has special
26 circumstances in accordance with the dictates of medical prudence.

27 (c) The treating physician or health care provider shall

1 identify a special circumstance. The treating physician or health
2 care provider shall:

3 (1) request that the insured be permitted to continue
4 treatment under the physician's or provider's care; and

5 (2) agree not to seek payment from the insured of any
6 amount for which the insured would not be responsible if the
7 physician or provider were still a preferred provider. (V.T.I.C.
8 Art. 3.70-3C, Secs. 1(7), 4(b), (c), as added Acts 75th Leg., R.S.,
9 Ch. 1024.)

10 Sec. 1301.154. OBLIGATION FOR CONTINUITY OF CARE OF
11 INSURER. (a) Except as provided by Subsection (b), Sections
12 1301.152 and 1301.153 do not extend an insurer's obligation to
13 reimburse the terminated physician or provider or, if applicable,
14 the insured at the preferred provider level of coverage for ongoing
15 treatment of an insured after:

16 (1) the 90th day after the effective date of the
17 termination; or

18 (2) if the insured has been diagnosed as having a
19 terminal illness at the time of the termination, the expiration of
20 the nine-month period after the effective date of the termination.

21 (b) If an insured is past the 24th week of pregnancy at the
22 time of termination, an insurer's obligation to reimburse, at the
23 preferred provider level of coverage, the physician or provider or,
24 if applicable, the insured, extends through delivery of the child,
25 immediate postpartum care, and the follow-up checkup within the
26 six-week period after delivery. (V.T.I.C. Art. 3.70-3C, Sec. 4(e),
27 as added Acts 75th Leg., R.S., Ch. 1024.)

1 Sec. 1301.155. EMERGENCY CARE. (a) In this section,
2 "emergency care" means health care services provided in a hospital
3 emergency facility or comparable facility to evaluate and stabilize
4 a medical condition of a recent onset and severity, including
5 severe pain, that would lead a prudent layperson possessing an
6 average knowledge of medicine and health to believe that the
7 person's condition, sickness, or injury is of such a nature that
8 failure to get immediate medical care could result in:

- 9 (1) placing the person's health in serious jeopardy;
10 (2) serious impairment to bodily functions;
11 (3) serious dysfunction of a bodily organ or part;
12 (4) serious disfigurement; or
13 (5) in the case of a pregnant woman, serious jeopardy
14 to the health of the fetus.

15 (b) If an insured cannot reasonably reach a preferred
16 provider, an insurer shall provide reimbursement for the following
17 emergency care services at the preferred level of benefits until
18 the insured can reasonably be expected to transfer to a preferred
19 provider:

20 (1) a medical screening examination or other
21 evaluation required by state or federal law to be provided in the
22 emergency facility of a hospital that is necessary to determine
23 whether a medical emergency condition exists;

24 (2) necessary emergency care services, including the
25 treatment and stabilization of an emergency medical condition; and

26 (3) services originating in a hospital emergency
27 facility following treatment or stabilization of an emergency

1 medical condition. (V.T.I.C. Art. 3.70-3C, Secs. 1(1), 5, as added
2 Acts 75th Leg., R.S., Ch. 1024.)

3 Sec. 1301.156. PAYMENT OF CLAIMS TO INSURED. An insurer
4 shall comply with Subchapter B, Chapter 542, with respect to prompt
5 payment to insureds. (V.T.I.C. Art. 3.70-3C, Sec. 3(m) (part), as
6 added Acts 75th Leg., R.S., Ch. 1024.)

7 Sec. 1301.157. PLAIN LANGUAGE REQUIREMENTS. Each health
8 insurance policy, health benefit plan certificate, endorsement,
9 amendment, application, or rider must:

- 10 (1) be written in plain language;
11 (2) be in a readable and understandable format; and
12 (3) comply with all applicable requirements relating
13 to minimum readability requirements. (V.T.I.C. Art. 3.70-3C, Sec.
14 6(a), as added Acts 75th Leg., R.S., Ch. 1024.)

15 Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER
16 BENEFIT PLANS. (a) In this section, "prospective insured" means:

17 (1) for group coverage, an individual or an
18 individual's dependent who is eligible for coverage under a health
19 insurance policy issued to the group; or

20 (2) for individual coverage, an individual or an
21 individual's dependent who is eligible for coverage and who has
22 expressed an interest in purchasing an individual health insurance
23 policy.

24 (b) An insurer shall provide to a current or prospective
25 group contract holder or current or prospective insured on request
26 an accurate written description of the terms of the health
27 insurance policy to allow the current or prospective group contract

holder or current or prospective insured to make comparisons and an informed decision before selecting among health care plans. The description must be in a readable and understandable format as prescribed by the commissioner and must include a current list of preferred providers. The insurer may satisfy this requirement by providing its handbook if:

(1) the handbook's content is substantively similar to and achieves the same level of disclosure as the written description prescribed by the commissioner; and

(2) the current list of preferred providers is provided.

(c) An insurer or an agent or representative of an insurer may not use or distribute, or permit the use or distribution of, information for prospective insureds that is untrue or misleading. (V.T.I.C. Art. 3.70-3C, Secs. 1(11), 6(b), (d), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.159. ANNUAL LIST OF PREFERRED PROVIDERS. A current list of preferred providers shall be provided to each insured at least annually. (V.T.I.C. Art. 3.70-3C, Sec. 6(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Sec. 1301.160. NOTIFICATION OF TERMINATION OF PARTICIPATION OF PREFERRED PROVIDER. (a) If a practitioner's participation in a preferred provider benefit plan is terminated for a reason other than at the practitioner's request, an insurer may not notify insureds of the termination until the later of:

(1) the effective date of the termination; or

(2) the time at which a review panel makes a formal

1 recommendation regarding the termination.

2 (b) A physician or health care provider that voluntarily
3 terminates the physician's or provider's participation in a
4 preferred provider benefit plan shall provide reasonable notice to
5 each insured under the physician's or provider's care. The insurer
6 shall provide assistance to the physician or provider in ensuring
7 that the notice requirements of this subsection are met.

8 (c) If a practitioner's participation in a preferred
9 provider benefit plan is terminated for reasons related to imminent
10 harm, an insurer may notify insureds immediately. (V.T.I.C. Art.
11 3.70-3C, Sec. 6(e), as added Acts 75th Leg., R.S., Ch. 1024.)

12 Sec. 1301.161. RETALIATION AGAINST INSURED PROHIBITED. An
13 insurer may not engage in any retaliatory action against an
14 insured, including canceling or refusing to renew a health
15 insurance policy, because the insured or a person acting on the
16 insured's behalf has:

17 (1) filed a complaint against the insurer or against a
18 preferred provider; or

19 (2) appealed a decision of the insurer. (V.T.I.C.
20 Art. 3.70-3C, Sec. 7(a), as added Acts 75th Leg., R.S., Ch. 1024.)

21 [Sections 1301.162-1301.200 reserved for expansion]

22 SUBCHAPTER E. CERTAIN HEALTH CARE PROVIDERS

23 Sec. 1301.201. CONTRACTS WITH AND REIMBURSEMENT FOR NURSE
24 FIRST ASSISTANTS. A preferred provider may not refuse to:

25 (1) contract with a nurse first assistant, as defined
26 by Section 301.1525, Occupations Code, to be included in the
27 provider's network; or

(2) reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform. (V.T.I.C. Art. 3.70-3C, Sec. 3(o), as added Acts 75th Leg., R.S., Ch. 1024.)

[Chapters 1302-1350 reserved for expansion]

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1351. HOME HEALTH SERVICES

Sec. 1351.001. DEFINITIONS

Sec. 1351.002. APPLICABILITY OF CHAPTER

Sec. 1351.003. APPLICABILITY OF GENERAL PROVISIONS OF
OTHER LAW

Sec. 1351.004. EXCEPTION

Sec. 1351.005. COVERAGE REQUIRED

Sec. 1351.006. REIMBURSEMENT FOR HOME HEALTH SERVICES:
PHYSICIAN CERTIFICATION REQUIRED

Sec. 1351.007. LIMITATIONS AND EXCLUSIONS ON COVERAGE
PERMITTED

Sec. 1351.008. REJECTION OF COVERAGE BY PLAN HOLDER;
NEGOTIATION OF ALTERNATIVE COVERAGE

Sec. 1351.009. ADDITIONAL COVERAGE NOT PRECLUDED

CHAPTER 1351. HOME HEALTH SERVICES

Sec. 1351.001. DEFINITIONS. In this chapter:

(1) "Health services" includes:

(A) skilled nursing by a registered nurse or a licensed vocational nurse under the supervision of at least one registered nurse and at least one physician;

(B) physical, occupational, speech, or

1 respiratory therapy;

2 (C) the services of a home health aide under the
3 supervision of a registered nurse; and

4 (D) the furnishing of medical equipment and
5 supplies other than drugs or medicines.

6 (2) "Home health agency" means a business that:

7 (A) provides home health services; and

8 (B) is licensed by the Texas Department of Human
9 Services under Chapter 142, Health and Safety Code.

10 (3) "Home health services" means the provision of
11 health services for payment or other consideration in a patient's
12 residence under a plan of care that is:

13 (A) established, approved in writing, and
14 reviewed at least every two months by the attending physician; and

15 (B) certified by the attending physician as
16 necessary for medical purposes. (V.T.I.C. Art. 3.70-3B, Sec. 1.)

17 Sec. 1351.002. APPLICABILITY OF CHAPTER. (a) This chapter
18 applies to a group health benefit plan that is delivered or issued
19 for delivery in this state and that is a group policy of accident
20 and health insurance, including a policy issued by a group hospital
21 service corporation operating under Chapter 842.

22 (b) This chapter applies to an accident and health insurance
23 policy issued by a stipulated premium company subject to Chapter
24 884. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part); Art. 3.70-8, Secs.
25 (a) (part), (b).)

26 Sec. 1351.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
27 LAW. The provisions of Chapter 1201, including provisions relating

1 to the applicability, purpose, and enforcement of that chapter, the
2 construction of policies under that chapter, rulemaking under that
3 chapter, and definitions of terms applicable in that chapter, apply
4 to this chapter. (New.)

5 Sec. 1351.004. EXCEPTION. This chapter does not apply to:

6 (1) a group policy of accident and health insurance
7 that provides coverage only for:

8 (A) a specified disease or diseases;

9 (B) vision care;

10 (C) dental care;

11 (D) hospital indemnity;

12 (E) prescription drugs; or

13 (F) other limited benefits;

14 (2) a blanket insurance policy, as described by
15 Chapter 1251;

16 (3) a short-term travel insurance policy;

17 (4) an accident-only insurance policy;

18 (5) a hospital indemnity insurance policy;

19 (6) a limited or specified disease insurance policy;

20 (7) an insurance policy or contract issued under a
21 right of conversion; or

22 (8) an insurance policy or contract designed for
23 issuance to a person eligible for Medicare coverage. (V.T.I.C.
24 Art. 3.70-3B, Sec. 2(c).)

25 Sec. 1351.005. COVERAGE REQUIRED. Except as provided by
26 Section 1351.008, a group health benefit plan must provide coverage
27 for home health services provided by a home health agency.

(V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

Sec. 1351.006. REIMBURSEMENT FOR HOME HEALTH SERVICES:
PHYSICIAN CERTIFICATION REQUIRED. A group health benefit plan
issuer may not provide reimbursement for home health services
provided under the plan unless the attending physician certifies
that hospitalization or confinement in a skilled facility would be
required if a treatment plan for home health care were not provided.
(V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

Sec. 1351.007. LIMITATIONS AND EXCLUSIONS ON COVERAGE
PERMITTED. (a) A group health benefit plan may include:

(1) a limitation on the number of visits for home
health services for which benefits are payable, subject to
Subsection (b);

(2) an exclusion for home health services coverage
for:

(A) custodial care;

(B) services provided by an individual who:

(i) resides in the covered individual's
home; or

(ii) is a member of the covered individual's
family; or

(C) services provided to a covered individual who
is eligible for Medicare coverage;

(3) annual deductible and coinsurance provisions for
home health services coverage that are not less favorable than the
deductible or coinsurance provisions applicable to hospital
services coverage under the plan; and

1 (4) other coverage limitations or exclusions
2 consistent with the remaining provisions of the plan.

3 (b) A limitation under Subsection (a)(1) may not limit each
4 individual covered under the plan to fewer than 60 visits in any
5 calendar year or continuous 12-month period.

6 (c) For purposes of this section, each of the following is
7 considered to be one visit for home health services:

8 (1) a visit by a representative of a home health
9 agency;

10 (2) four hours of home health aide service; and

11 (3) if home health aide service extends beyond four
12 hours, each additional four hours or portion of that four-hour
13 period. (V.T.I.C. Art. 3.70-3B, Secs. 3(a), (b), (c).)

14 Sec. 1351.008. REJECTION OF COVERAGE BY PLAN HOLDER;
15 NEGOTIATION OF ALTERNATIVE COVERAGE. (a) If the holder of a group
16 health benefit plan rejects in writing the coverage required under
17 this chapter, the plan issuer:

18 (1) may not include the coverage in the plan; and

19 (2) is not required to:

20 (A) offer the coverage to the plan holder; or

21 (B) provide the coverage under the plan.

22 (b) If a plan holder rejects in writing the coverage
23 required under this chapter, the plan holder and the plan issuer may
24 negotiate coverage for home health services other than the coverage
25 required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 2(b).)

26 Sec. 1351.009. ADDITIONAL COVERAGE NOT PRECLUDED. This
27 chapter does not preclude a group health benefit plan issuer from

1 providing coverage for home health services that exceeds the
2 coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec.
3 3(d).)

4 CHAPTER 1352. BRAIN INJURY

5 Sec. 1352.001. APPLICABILITY OF CHAPTER

6 Sec. 1352.002. EXCEPTION

7 Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED

8 Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED

9 CHAPTER 1352. BRAIN INJURY

10 Sec. 1352.001. APPLICABILITY OF CHAPTER. This chapter
11 applies only to a health benefit plan, including a small employer
12 health benefit plan written under Chapter 1501, that provides
13 benefits for medical or surgical expenses incurred as a result of a
14 health condition, accident, or sickness, including an individual,
15 group, blanket, or franchise insurance policy or insurance
16 agreement, a group hospital service contract, or an individual or
17 group evidence of coverage or similar coverage document that is
18 offered by:

19 (1) an insurance company;

20 (2) a group hospital service corporation operating
21 under Chapter 842;

22 (3) a fraternal benefit society operating under
23 Chapter 885;

24 (4) a stipulated premium company operating under
25 Chapter 884;

26 (5) a reciprocal exchange operating under Chapter 942;

27 (6) a Lloyd's plan operating under Chapter 941;

1 (7) a health maintenance organization operating under
2 Chapter 843;

3 (8) a multiple employer welfare arrangement that holds
4 a certificate of authority under Chapter 846; or

5 (9) an approved nonprofit health corporation that
6 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
7 21.53Q, Secs. 1(a), (b).)

8 Sec. 1352.002. EXCEPTION. This chapter does not apply to:

9 (1) a plan that provides coverage:

10 (A) only for a specified disease or for another
11 limited benefit other than an accident policy;

12 (B) only for accidental death or dismemberment;

13 (C) for wages or payments in lieu of wages for a
14 period during which an employee is absent from work because of
15 sickness or injury;

16 (D) as a supplement to a liability insurance
17 policy;

18 (E) for credit insurance;

19 (F) only for dental or vision care;

20 (G) only for hospital expenses; or

21 (H) only for indemnity for hospital confinement;

22 (2) a Medicare supplemental policy as defined by
23 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
24 as amended;

25 (3) a workers' compensation insurance policy;

26 (4) medical payment insurance coverage provided under
27 a motor vehicle insurance policy; or

1 (5) a long-term care insurance policy, including a
2 nursing home fixed indemnity policy, unless the commissioner
3 determines that the policy provides benefit coverage so
4 comprehensive that the policy is a health benefit plan as described
5 by Section 1352.001. (V.T.I.C. Art. 21.53Q, Sec. 1(c).)

6 Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED. (a) A
7 health benefit plan may not exclude coverage for cognitive
8 rehabilitation therapy, cognitive communication therapy,
9 neurocognitive therapy and rehabilitation, neurobehavioral,
10 neurophysiological, neuropsychological, or psychophysiological
11 testing or treatment, neurofeedback therapy, remediation,
12 post-acute transition services, or community reintegration
13 services necessary as a result of and related to an acquired brain
14 injury.

15 (b) Coverage required under this chapter may be subject to
16 deductibles, copayments, coinsurance, or annual or maximum payment
17 limits that are consistent with the deductibles, copayments,
18 coinsurance, or annual or maximum payment limits applicable to
19 other similar coverage provided under the health benefit plan.

20 (c) The commissioner shall adopt rules as necessary to
21 implement this section. (V.T.I.C. Art. 21.53Q, Sec. 2.)

22 Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED.

23 (a) In this section, "preauthorization" means the provision of a
24 reliable representation to a physician or health care provider of
25 whether a health benefit plan issuer will pay the physician or
26 provider for proposed medical or health care services if the
27 physician or provider provides those services to the patient for

1 whom the services are proposed. The term includes
2 precertification, certification, recertification, or any other
3 activity that involves providing a reliable representation by the
4 issuer to a physician or health care provider.

5 (b) The commissioner by rule shall require a health benefit
6 plan issuer to provide adequate training to personnel responsible
7 for preauthorization of coverage or utilization review under the
8 plan. The purpose of the training is to prevent denial of coverage
9 in violation of Section 1352.003 and to avoid confusion of medical
10 benefits with mental health benefits. (V.T.I.C. Art. 21.53Q, Sec.
11 3.)

12 CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS UNDER
13 MANAGED CARE PLANS

14 Sec. 1353.001. PROHIBITED CONDUCT

15 Sec. 1353.002. RULES

16 CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS UNDER
17 MANAGED CARE PLANS

18 Sec. 1353.001. PROHIBITED CONDUCT. A managed care entity
19 may not:

20 (1) require a physician participating in a managed
21 care plan to issue an immunization or vaccination protocol for an
22 immunization or vaccination to be administered to an enrollee in
23 the plan;

24 (2) limit an enrollee's benefits for immunizations or
25 vaccinations to circumstances in which an immunization or
26 vaccination protocol is issued;

27 (3) provide a financial incentive to a physician to

1 issue an immunization or vaccination protocol; or

2 (4) impose a financial or other penalty on a physician
3 who refuses to issue an immunization or vaccination protocol.
4 (V.T.I.C. Art. 21.53K, Sec. 1.)

5 Sec. 1353.002. RULES. The commissioner may adopt rules to
6 implement this chapter. (V.T.I.C. Art. 21.53K, Sec. 2.)

7 CHAPTER 1354. ELIGIBILITY FOR BENEFITS FOR ALZHEIMER'S DISEASE

8 Sec. 1354.001. APPLICABILITY OF CHAPTER

9 Sec. 1354.002. PROOF OF ORGANIC DISEASE

10 CHAPTER 1354. ELIGIBILITY FOR BENEFITS FOR ALZHEIMER'S DISEASE

11 Sec. 1354.001. APPLICABILITY OF CHAPTER. This chapter
12 applies only to a health benefit plan that:

13 (1) provides coverage for Alzheimer's disease; and

14 (2) is an individual or group policy, contract,
15 certificate, or evidence of coverage that is delivered or issued
16 for delivery in this state by an insurer or a group hospital service
17 corporation operating under Chapter 842. (V.T.I.C. Art. 3.78
18 (part).)

19 Sec. 1354.002. PROOF OF ORGANIC DISEASE. If a health
20 benefit plan requires demonstrable proof of organic disease or
21 other proof before the health benefit plan issuer will authorize
22 payment of benefits for Alzheimer's disease, that proof requirement
23 is satisfied by a clinical diagnosis of Alzheimer's disease made by
24 a physician licensed in this state, including a history and
25 physical, neurological, and psychological or psychiatric
26 evaluations, and laboratory studies. (V.T.I.C. Art. 3.78 (part).)

27 CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

SUBCHAPTER A. GROUP HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN
SERIOUS MENTAL ILLNESSES

Sec. 1355.001. DEFINITIONS

Sec. 1355.002. APPLICABILITY OF SUBCHAPTER

Sec. 1355.003. EXCEPTION

Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL
ILLNESS

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED

Sec. 1355.006. COVERAGE FOR CERTAIN CONDITIONS RELATED TO
CONTROLLED SUBSTANCE OR MARIHUANA NOT
REQUIRED

Sec. 1355.007. SMALL EMPLOYER COVERAGE

[Sections 1355.008-1355.050 reserved for expansion]

SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT
BENEFITS

Sec. 1355.051. DEFINITIONS

Sec. 1355.052. APPLICABILITY OF SUBCHAPTER

Sec. 1355.053. REQUIRED COVERAGE FOR CERTAIN ILLNESSES
AND DISORDERS

Sec. 1355.054. CONDITIONS FOR COVERAGE

Sec. 1355.055. DETERMINATIONS FOR TREATMENT IN A
RESIDENTIAL TREATMENT CENTER FOR CHILDREN
AND ADOLESCENTS

Sec. 1355.056. DETERMINATIONS FOR TREATMENT BY A
CRISIS STABILIZATION UNIT

Sec. 1355.057. REVIEW AND ADJUSTMENT OF MINIMUM
RATIOS OF REIMBURSEMENT

1 Sec. 1355.058. ASSISTANCE OF THE TEXAS DEPARTMENT OF
2 MENTAL HEALTH AND MENTAL RETARDATION
3 [Sections 1355.059-1355.100 reserved for expansion]

4 SUBCHAPTER C. PSYCHIATRIC DAY TREATMENT FACILITIES

5 Sec. 1355.101. DEFINITION

6 Sec. 1355.102. APPLICABILITY OF SUBCHAPTER

7 Sec. 1355.103. APPLICABILITY OF GENERAL PROVISIONS OF
8 OTHER LAW

9 Sec. 1355.104. REQUIRED COVERAGE FOR TREATMENT IN
10 PSYCHIATRIC DAY TREATMENT FACILITY

11 Sec. 1355.105. DETERMINATIONS FOR TREATMENT IN PSYCHIATRIC
12 DAY TREATMENT FACILITY

13 Sec. 1355.106. OFFER OF COVERAGE REQUIRED; ALTERNATIVE
14 BENEFITS

15 [Sections 1355.107-1355.150 reserved for expansion]

16 SUBCHAPTER D. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

17 Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION OF
18 CERTAIN COVERAGES

19 [Sections 1355.152-1355.200 reserved for expansion]

20 SUBCHAPTER E. BENEFITS FOR TREATMENT BY
21 TAX-SUPPORTED INSTITUTION

22 Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF
23 OTHER LAW

24 Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH
25 OR MENTAL RETARDATION BENEFITS FOR
26 TREATMENT BY TAX-SUPPORTED INSTITUTION

27 CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

SUBCHAPTER A. GROUP HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN

SERIOUS MENTAL ILLNESSES

Sec. 1355.001. DEFINITIONS. In this subchapter:

(1) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

(A) bipolar disorders (hypomanic, manic, depressive, and mixed);

(B) depression in childhood and adolescence;

(C) major depressive disorders (single episode or recurrent);

(D) obsessive-compulsive disorders;

(E) paranoid and other psychotic disorders;

(F) pervasive developmental disorders;

(G) schizo-affective disorders (bipolar or depressive); and

(H) schizophrenia.

(2) "Small employer" has the meaning assigned by Section 1501.002. (V.T.I.C. Art. 3.51-14, Secs. 1(1), (3).)

Sec. 1355.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) a group insurance policy, group insurance agreement, group hospital service contract, or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843; and

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan offered under:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement.
(V.T.I.C. Art. 3.51-14, Sec. 2(a).)

Sec. 1355.003. EXCEPTION. (a) This subchapter does not apply to coverage under:

(1) a blanket accident and health insurance policy, as described by Chapter 1251;

(2) a short-term travel policy;

(3) an accident-only policy;

(4) a limited or specified-disease policy that does not provide benefits for mental health care or similar services;

(5) except as provided by Subsection (b), a plan offered under Chapter 1551 or Chapter 1601;

(6) a plan offered in accordance with Section 1355.151; or

1 (7) a Medicare supplement benefit plan, as defined by
2 Section 1652.002.

3 (b) For the purposes of a plan described by Subsection
4 (a)(5), "serious mental illness" has the meaning assigned by
5 Section 1355.001. (V.T.I.C. Art. 3.51-14, Sec. 2(b).)

6 Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL
7 ILLNESS. (a) A group health benefit plan:

8 (1) must provide coverage, based on medical necessity,
9 for not less than the following treatments of serious mental
10 illness in each calendar year:

11 (A) 45 days of inpatient treatment; and

12 (B) 60 visits for outpatient treatment,
13 including group and individual outpatient treatment;

14 (2) may not include a lifetime limitation on the
15 number of days of inpatient treatment or the number of visits for
16 outpatient treatment covered under the plan; and

17 (3) must include the same amount limitations,
18 deductibles, copayments, and coinsurance factors for serious
19 mental illness as the plan includes for physical illness.

20 (b) A group health benefit plan issuer:

21 (1) may not count an outpatient visit for medication
22 management against the number of outpatient visits required to be
23 covered under Subsection (a)(1)(B); and

24 (2) must provide coverage for an outpatient visit
25 described by Subsection (a)(1)(B) under the same terms as the
26 coverage the issuer provides for an outpatient visit for the
27 treatment of physical illness. (V.T.I.C. Art. 3.51-14, Secs. 3(a),

(b).)

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A group health benefit plan issuer may provide or offer coverage required by Section 1355.004 through a managed care plan. (V.T.I.C. Art. 3.51-14, Sec. 3(c).)

Sec. 1355.006. COVERAGE FOR CERTAIN CONDITIONS RELATED TO CONTROLLED SUBSTANCE OR MARIHUANA NOT REQUIRED. (a) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

(b) This subchapter does not require a group health benefit plan to provide coverage for the treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness that results from the use of a controlled substance or marihuana in violation of law. (V.T.I.C. Art. 3.51-14, Sec. 5.)

Sec. 1355.007. SMALL EMPLOYER COVERAGE. An issuer of a group health benefit plan to a small employer must offer the coverage described by Section 1355.004 to the employer but is not required to provide the coverage if the employer rejects the coverage. (V.T.I.C. Art. 3.51-14, Sec. 4.)

[Sections 1355.008-1355.050 reserved for expansion]

SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT

BENEFITS

Sec. 1355.051. DEFINITIONS. In this subchapter:

(1) "Crisis stabilization unit" means a 24-hour residential program that provides, usually for a short term,

1 intensive supervision and highly structured activities to
2 individuals who demonstrate a moderate to severe acute psychiatric
3 crisis.

4 (2) "Individual treatment plan" means a treatment plan
5 with specific attainable goals and objectives that are appropriate
6 to:

7 (A) the patient; and

8 (B) the program's treatment modality.

9 (3) "Residential treatment center for children and
10 adolescents" means a child-care institution that:

11 (A) is accredited as a residential treatment
12 center by:

13 (i) the Council on Accreditation;

14 (ii) the Joint Commission on Accreditation
15 of Healthcare Organizations; or

16 (iii) the American Association of
17 Psychiatric Services for Children; and

18 (B) provides residential care and treatment for
19 emotionally disturbed children and adolescents. (V.T.I.C. Art.
20 3.72, Subsec. (a).)

21 Sec. 1355.052. APPLICABILITY OF SUBCHAPTER. This
22 subchapter applies to a group health benefit plan that is delivered
23 or issued for delivery in this state and that is:

24 (1) an accident and health insurance group policy;

25 (2) a group policy issued by a group hospital service
26 corporation operating under Chapter 842; or

27 (3) a group health care plan provided by a health

1 maintenance organization operating under Chapter 843. (V.T.I.C.
2 Art. 3.72, Subsec. (b) (part).)

3 Sec. 1355.053. REQUIRED COVERAGE FOR CERTAIN ILLNESSES AND
4 DISORDERS. A group health benefit plan that provides coverage for
5 treatment of mental or emotional illness or disorder for a covered
6 individual when the individual is confined in a hospital must also
7 provide coverage for treatment in a residential treatment center
8 for children and adolescents or a crisis stabilization unit that is
9 at least as favorable as the coverage the plan provides for
10 treatment of mental or emotional illness or disorder in a hospital.
11 (V.T.I.C. Art. 3.72, Subsec. (b) (part).)

12 Sec. 1355.054. CONDITIONS FOR COVERAGE. (a) Benefits of
13 coverage provided under this subchapter may be used only in a
14 situation in which:

15 (1) the covered individual has a serious mental
16 illness that requires confinement of the individual in a hospital
17 unless treatment is available through a residential treatment
18 center for children and adolescents or a crisis stabilization unit;
19 and

20 (2) the covered individual's mental illness:

21 (A) substantially impairs the individual's
22 thought, perception of reality, emotional process, or judgment; or

23 (B) as manifested by the individual's recent
24 disturbed behavior, grossly impairs the individual's behavior.

25 (b) The service for which benefits are to be paid from
26 coverage provided under this subchapter must be:

27 (1) based on an individual treatment plan for the

1 covered individual; and

2 (2) provided by a service provider licensed or
3 operated by the appropriate state agency to provide those services.

4 (c) Benefits under coverage provided under this subchapter
5 are subject to the same benefit maximums, durational limitations,
6 deductibles, and coinsurance factors that apply to inpatient
7 psychiatric treatment under the coverage. (V.T.I.C. Art. 3.72,
8 Subsec. (c).)

9 Sec. 1355.055. DETERMINATIONS FOR TREATMENT IN A
10 RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS. (a)
11 Treatment in a residential treatment center for children and
12 adolescents must be determined as if necessary care and treatment
13 were inpatient care and treatment in a hospital.

14 (b) For the purposes of determining policy benefits and
15 benefit maximums, each two days of treatment in a residential
16 treatment center for children and adolescents is the equivalent of
17 one day of treatment of mental or emotional illness or disorder in a
18 hospital or inpatient program. (V.T.I.C. Art. 3.72, Subsec. (d).)

19 Sec. 1355.056. DETERMINATIONS FOR TREATMENT BY A CRISIS
20 STABILIZATION UNIT. (a) Treatment by a crisis stabilization unit
21 must be determined as if necessary care and treatment were
22 inpatient care and treatment in a hospital.

23 (b) For the purposes of determining plan benefits and
24 benefit maximums, each two days of treatment in a crisis
25 stabilization unit is the equivalent of one day of treatment of
26 mental or emotional illness or disorder in a hospital or inpatient
27 program.

1 (c) Treatment provided to an individual by a crisis
2 stabilization unit licensed or certified by the Texas Department of
3 Mental Health and Mental Retardation shall be reimbursed.
4 (V.T.I.C. Art. 3.72, Subsec. (e).)

5 Sec. 1355.057. REVIEW AND ADJUSTMENT OF MINIMUM RATIOS OF
6 REIMBURSEMENT. (a) The commissioner shall monitor and review the
7 minimum ratios of reimbursement for alternative treatments
8 required by Sections 1355.055 and 1355.056.

9 (b) If the commissioner finds that the limits provided by
10 this subchapter are creating an artificial increase in the costs of
11 services, the commissioner by rule may adjust the ratios to the
12 extent necessary to prevent the artificial increase.

13 (c) Before the commissioner adjusts a ratio under
14 Subsection (b), the commissioner must give notice and hold a
15 hearing to:

16 (1) consider information related to the adjustment;
17 and

18 (2) determine whether the information justifies the
19 adjustment.

20 (d) The department shall review the reimbursement ratios at
21 least every two years. (V.T.I.C. Art. 3.72, Subsec. (f) (part).)

22 Sec. 1355.058. ASSISTANCE OF THE TEXAS DEPARTMENT OF MENTAL
23 HEALTH AND MENTAL RETARDATION. (a) The Texas Department of Mental
24 Health and Mental Retardation shall assist the department in
25 carrying out the department's responsibilities under this
26 subchapter.

27 (b) The department and the Texas Department of Mental Health

1 and Mental Retardation by rule may adopt a memorandum of
2 understanding to carry out this subchapter. (V.T.I.C. Art. 3.72,
3 Subsec. (g).)

4 [Sections 1355.059-1355.100 reserved for expansion]

5 SUBCHAPTER C. PSYCHIATRIC DAY TREATMENT FACILITIES

6 Sec. 1355.101. DEFINITION. In this subchapter,
7 "psychiatric day treatment facility" means a mental health facility
8 that:

9 (1) provides treatment for individuals suffering from
10 acute mental and nervous disorders in a structured psychiatric
11 program using individualized treatment plans with specific
12 attainable goals and objectives that are appropriate to the patient
13 and the program's treatment modality; and

14 (2) is clinically supervised by a doctor of medicine
15 who is certified in psychiatry by the American Board of Psychiatry
16 and Neurology. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

17 Sec. 1355.102. APPLICABILITY OF SUBCHAPTER. This
18 subchapter applies to a group policy of accident and health
19 insurance delivered or issued for delivery in this state, including
20 a group policy issued by a group hospital service corporation
21 operating under Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (F)
22 (part).)

23 Sec. 1355.103. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
24 LAW. The provisions of Chapter 1201, including provisions relating
25 to the applicability, purpose, and enforcement of that chapter,
26 construction of policies under that chapter, rulemaking under that
27 chapter, and definitions of terms applicable in that chapter, apply

1 to this subchapter. (New.)

2 Sec. 1355.104. REQUIRED COVERAGE FOR TREATMENT IN
3 PSYCHIATRIC DAY TREATMENT FACILITY. (a) A group insurance policy
4 that provides coverage for treatment of mental or emotional illness
5 or disorder when an individual is confined in a hospital must also
6 provide coverage for treatment obtained under the direction and
7 continued medical supervision of a doctor of medicine or doctor of
8 osteopathy in a psychiatric day treatment facility that provides
9 organizational structure and individualized treatment plans
10 separate from an inpatient program.

11 (b) The psychiatric day treatment facility coverage
12 required by this section may not be less favorable than the hospital
13 coverage and must be subject to the same durational limits,
14 deductibles, and coinsurance factors.

15 (c) A group insurance policy subject to this section may
16 require that:

17 (1) the treatment obtained in a psychiatric day
18 treatment facility be provided by a facility that treats a patient
19 for not more than 8 hours in any 24-hour period;

20 (2) the attending physician certify that the treatment
21 is in lieu of hospitalization; and

22 (3) the psychiatric day treatment facility be
23 accredited by the Program for Psychiatric Facilities, or its
24 successor, of the Joint Commission on Accreditation of Healthcare
25 Organizations. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

26 Sec. 1355.105. DETERMINATIONS FOR TREATMENT IN PSYCHIATRIC
27 DAY TREATMENT FACILITY. (a) Benefits provided under this

1 subchapter shall be determined as if necessary care and treatment
2 in a psychiatric day treatment facility were inpatient care and
3 treatment in a hospital.

4 (b) For the purpose of determining policy benefits and
5 benefit maximums, each full day of treatment in a psychiatric day
6 treatment facility is the equivalent of one-half of one day of
7 treatment of mental or emotional illness or disorder in a hospital
8 or inpatient program. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

9 Sec. 1355.106. OFFER OF COVERAGE REQUIRED; ALTERNATIVE
10 BENEFITS. (a) An insurer shall offer, and a policyholder is
11 entitled to reject, coverage under a group insurance policy for
12 treatment of mental or emotional illness or disorder when confined
13 in a hospital or in a psychiatric day treatment facility.

14 (b) A policyholder may select an alternative level of
15 benefits under the group insurance policy if the alternative level
16 is offered by or negotiated with the insurer.

17 (c) The alternative level of benefits must provide policy
18 benefits and benefit maximums for treatment in a psychiatric day
19 treatment facility equal to at least one-half of that provided for
20 treatment in a hospital, except that benefits for treatment in a
21 psychiatric day treatment facility may not exceed the usual and
22 customary charges of the facility. (V.T.I.C. Art. 3.70-2, Sec. (F)
23 (part).)

24 [Sections 1355.107-1355.150 reserved for expansion]

25 SUBCHAPTER D. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

26 Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION OF
27 CERTAIN COVERAGES. (a) In this section, "serious mental illness"

1 has the meaning assigned by Section 1355.001.

2 (b) A political subdivision that provides group health
3 insurance coverage, health maintenance organization coverage, or
4 self-insured health care coverage to the political subdivision's
5 officers or employees may not contract for or provide coverage that
6 is less extensive for serious mental illness than the coverage
7 provided for any other physical illness. (V.T.I.C. Art. 3.51-5A,
8 Subsecs. (a) (part), (b).)

9 [Sections 1355.152-1355.200 reserved for expansion]

10 SUBCHAPTER E. BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION

11 Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
12 LAW. The provisions of Chapter 1201, including provisions relating
13 to the applicability, purpose, and enforcement of that chapter,
14 construction of policies under that chapter, rulemaking under that
15 chapter, and definitions of terms applicable in that chapter, apply
16 to this subchapter. (New.)

17 Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH OR
18 MENTAL RETARDATION BENEFITS FOR TREATMENT BY TAX-SUPPORTED
19 INSTITUTION. (a) An individual or group accident and health
20 insurance policy delivered or issued for delivery to a person in
21 this state that provides coverage for mental illness or mental
22 retardation may not exclude benefits under that coverage for
23 support, maintenance, and treatment provided by a tax-supported
24 institution of this state, or by a community center for mental
25 health or mental retardation services, that regularly and
26 customarily charges patients who are not indigent for those
27 services.

(b) In determining whether a patient is not indigent, as provided by Subchapter B, Chapter 552, Health and Safety Code, a tax-supported institution of this state or a community center for mental health or mental retardation services shall consider any insurance policy or policies that provide coverage to the patient for mental illness or mental retardation. (V.T.I.C. Art. 3.70-2, Sec. (D).)

CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

Sec. 1356.001. DEFINITION

Sec. 1356.002. APPLICABILITY OF CHAPTER

Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER

LAW

Sec. 1356.004. EXCEPTION

Sec. 1356.005. COVERAGE REQUIRED

CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

Sec. 1356.001. DEFINITION. In this chapter, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Sec. 1356.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that is delivered, issued for delivery, or renewed in this state and that is an individual or group accident and health insurance policy, including a policy issued by a group hospital service corporation operating under

1 Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended
2 Acts 70th Leg., R.S., Ch. 1091.)

3 Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
4 LAW. The provisions of Chapter 1201, including provisions relating
5 to the applicability, purpose, and enforcement of that chapter,
6 construction of policies under that chapter, rulemaking under that
7 chapter, and definitions of terms applicable in that chapter, apply
8 to this chapter. (New.)

9 Sec. 1356.004. EXCEPTION. This chapter does not apply to a
10 plan that provides coverage only for a specified disease or for
11 another limited benefit. (V.T.I.C. Art. 3.70-2, Sec. (H) (part),
12 as amended Acts 70th Leg., R.S., Ch. 1091.)

13 Sec. 1356.005. COVERAGE REQUIRED. (a) A health benefit
14 plan that provides coverage to a female who is 35 years of age or
15 older must include coverage for an annual screening by low-dose
16 mammography for the presence of occult breast cancer.

17 (b) Coverage required by this section:

18 (1) may not be less favorable than coverage for other
19 radiological examinations under the plan; and

20 (2) must be subject to the same dollar limits,
21 deductibles, and coinsurance factors as coverage for other
22 radiological examinations under the plan. (V.T.I.C. Art. 3.70-2,
23 Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

24 CHAPTER 1357. MASTECTOMY

25 SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING

26 MASTECTOMY

27 Sec. 1357.001. DEFINITIONS

1 Sec. 1357.002. APPLICABILITY OF SUBCHAPTER

2 Sec. 1357.003. EXCEPTION

3 Sec. 1357.004. COVERAGE REQUIRED

4 Sec. 1357.005. PROHIBITED CONDUCT

5 Sec. 1357.006. NOTICE OF COVERAGE

6 Sec. 1357.007. RULES

7 [Sections 1357.008-1357.050 reserved for expansion]

8 SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY AND

9 CERTAIN RELATED PROCEDURES

10 Sec. 1357.051. DEFINITION

11 Sec. 1357.052. APPLICABILITY OF SUBCHAPTER

12 Sec. 1357.053. EXCEPTION

13 Sec. 1357.054. COVERAGE REQUIRED

14 Sec. 1357.055. PROHIBITED CONDUCT

15 Sec. 1357.056. NOTICE OF COVERAGE

16 Sec. 1357.057. RULES

17 CHAPTER 1357. MASTECTOMY

18 SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING

19 MASTECTOMY

20 Sec. 1357.001. DEFINITIONS. In this subchapter:

21 (1) "Breast reconstruction" means reconstruction of a
22 breast incident to mastectomy to restore or achieve breast
23 symmetry. The term includes surgical reconstruction of a breast on
24 which mastectomy has been performed and surgical reconstruction of
25 a breast on which mastectomy has not been performed.

26 (2) "Enrollee" means an individual entitled to
27 coverage under a health benefit plan. (V.T.I.C. Art. 21.53I, Secs.

1 1(2), (3).)

2 Sec. 1357.002. APPLICABILITY OF SUBCHAPTER. This
3 subchapter applies only to a health benefit plan that provides
4 benefits for medical or surgical expenses incurred as a result of a
5 health condition, accident, or sickness, including an individual,
6 group, blanket, or franchise insurance policy or insurance
7 agreement, a group hospital service contract, or an individual or
8 group evidence of coverage or similar coverage document that is
9 offered by:

- 10 (1) an insurance company;
- 11 (2) a group hospital service corporation operating
12 under Chapter 842;
- 13 (3) a fraternal benefit society operating under
14 Chapter 885;
- 15 (4) a stipulated premium company operating under
16 Chapter 884;
- 17 (5) a reciprocal exchange operating under Chapter 942;
- 18 (6) a health maintenance organization operating under
19 Chapter 843;
- 20 (7) a multiple employer welfare arrangement that holds
21 a certificate of authority under Chapter 846; or
- 22 (8) an approved nonprofit health corporation that
23 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
24 21.53I, Sec. 2(a).)

25 Sec. 1357.003. EXCEPTION. This subchapter does not apply
26 to:

- 27 (1) a plan that provides coverage:

1 (A) only for a specified disease or another
2 limited benefit, other than benefits for cancer;

3 (B) only for accidental death or dismemberment;

4 (C) only for wages or payments in lieu of wages
5 for a period during which an employee is absent from work because of
6 sickness or injury;

7 (D) only for credit insurance;

8 (E) only for dental or vision care;

9 (F) only for indemnity for hospital confinement;

10 or

11 (G) as a supplement to a liability insurance
12 policy;

13 (2) a Medicare supplemental policy as defined by
14 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
15 as amended;

16 (3) a workers' compensation insurance policy;

17 (4) medical payment insurance coverage provided under
18 a motor vehicle insurance policy; or

19 (5) a long-term care insurance policy, including a
20 nursing home fixed indemnity policy, unless the commissioner
21 determines that the policy provides benefit coverage so
22 comprehensive that the policy is a health benefit plan as described
23 by Section 1357.002. (V.T.I.C. Art. 21.53I, Sec. 2(b).)

24 Sec. 1357.004. COVERAGE REQUIRED. (a) A health benefit
25 plan that provides coverage for mastectomy must provide coverage
26 for:

27 (1) reconstruction of the breast on which the

1 mastectomy has been performed;

2 (2) surgery and reconstruction of the other breast to
3 achieve a symmetrical appearance; and

4 (3) prostheses and treatment of physical
5 complications, including lymphedemas, at all stages of mastectomy.

6 (b) Coverage required under this section:

7 (1) shall be provided in a manner determined to be
8 appropriate in consultation with the attending physician and the
9 enrollee;

10 (2) may be subject to annual deductibles, copayments,
11 and coinsurance that are consistent with annual deductibles,
12 copayments, and coinsurance required for other coverage under the
13 health benefit plan; and

14 (3) may not be subject to dollar limits other than the
15 lifetime maximum benefits under the plan. (V.T.I.C. Art. 21.53I,
16 Sec. 3.)

17 Sec. 1357.005. PROHIBITED CONDUCT. (a) An issuer of a
18 health benefit plan may not:

19 (1) offer a financial incentive for an enrollee to not
20 receive breast reconstruction or to waive the coverage required
21 under this subchapter;

22 (2) condition, limit, or deny the eligibility of a
23 person to enroll in the plan or to renew coverage under the terms of
24 the plan solely to avoid the requirements of this subchapter; or

25 (3) reduce or limit the reimbursement or amount paid
26 to, or otherwise penalize, an attending physician or provider or
27 provide a financial incentive or other benefit to an attending

1 physician or provider to induce the physician or provider to
2 provide care to an enrollee in a manner that is inconsistent with
3 this subchapter.

4 (b) This section does not prevent an issuer of a health
5 benefit plan from negotiating with a physician or provider the
6 level and type of reimbursement that the physician or provider will
7 receive for care provided in accordance with this subchapter.
8 (V.T.I.C. Art. 21.53I, Sec. 4.)

9 Sec. 1357.006. NOTICE OF COVERAGE. (a) An issuer of a
10 health benefit plan that provides coverage under this subchapter
11 shall provide to each enrollee notice of the availability of the
12 coverage.

13 (b) The notice must be provided in accordance with rules
14 adopted by the commissioner. (V.T.I.C. Art. 21.53I, Sec. 5.)

15 Sec. 1357.007. RULES. The commissioner may adopt rules to
16 implement this subchapter and to meet the minimum requirements of
17 federal law. (V.T.I.C. Art. 21.53I, Sec. 7.)

18 [Sections 1357.008-1357.050 reserved for expansion]

19 SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY AND
20 CERTAIN RELATED PROCEDURES

21 Sec. 1357.051. DEFINITION. In this subchapter, "enrollee"
22 means an individual entitled to coverage under a health benefit
23 plan. (V.T.I.C. Art. 21.52G, Sec. 1(1), as added Acts 75th Leg.,
24 R.S., Ch. 725.)

25 Sec. 1357.052. APPLICABILITY OF SUBCHAPTER. This
26 subchapter applies only to a health benefit plan that:

27 (1) provides benefits for medical or surgical expenses

1 incurred as a result of a health condition, accident, or sickness,
2 including:

3 (A) an individual, group, blanket, or franchise
4 insurance policy or insurance agreement, a group hospital service
5 contract, or an individual or group evidence of coverage that is
6 offered by:

7 (i) an insurance company;

8 (ii) a group hospital service corporation
9 operating under Chapter 842;

10 (iii) a fraternal benefit society operating
11 under Chapter 885;

12 (iv) a stipulated premium company operating
13 under Chapter 884; or

14 (v) a health maintenance organization
15 operating under Chapter 843; and

16 (B) to the extent permitted by the Employee
17 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
18 seq.), a health benefit plan that is offered by:

19 (i) a multiple employer welfare arrangement
20 as defined by Section 3 of that Act; or

21 (ii) another analogous benefit
22 arrangement;

23 (2) is offered by an approved nonprofit health
24 corporation that holds a certificate of authority under Chapter
25 844; or

26 (3) provides coverage only for a specific disease or
27 condition or for hospitalization. (V.T.I.C. Art. 21.52G, Secs.

2(a), (b), as added Acts 75th Leg., R.S., Ch. 725.)

Sec. 1357.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for accidental death or dismemberment;

(B) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(C) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1357.052. (V.T.I.C. Art. 21.52G, Sec. 2(c), as added Acts 75th Leg., R.S., Ch. 725.)

Sec. 1357.054. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for the treatment of breast cancer must provide to each enrollee coverage for inpatient care for a minimum of:

1 (1) 48 hours following a mastectomy; and

2 (2) 24 hours following a lymph node dissection for the
3 treatment of breast cancer.

4 (b) A health benefit plan is not required to provide the
5 minimum hours of coverage of inpatient care required under
6 Subsection (a) if the enrollee and the enrollee's attending
7 physician determine that a shorter period of inpatient care is
8 appropriate. (V.T.I.C. Art. 21.52G, Sec. 3, as added Acts 75th
9 Leg., R.S., Ch. 725.)

10 Sec. 1357.055. PROHIBITED CONDUCT. An issuer of a health
11 benefit plan may not:

12 (1) deny the eligibility or continued eligibility of
13 an individual to enroll in the plan or renew coverage under the plan
14 solely to avoid the requirements of this subchapter;

15 (2) provide money payments or rebates to an enrollee
16 to encourage the enrollee to accept less than the minimum coverage
17 required under this subchapter;

18 (3) reduce or limit the amount paid to an attending
19 physician, or otherwise penalize the physician, because the
20 physician provided care to an enrollee in accordance with this
21 subchapter; or

22 (4) provide financial or other incentives to an
23 attending physician to encourage the physician to provide care to
24 an enrollee in a manner inconsistent with this subchapter.
25 (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th Leg., R.S., Ch.
26 725.)

27 Sec. 1357.056. NOTICE OF COVERAGE. (a) An issuer of a

health benefit plan shall provide to each enrollee written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.52G, Sec. 5, as added Acts 75th Leg., R.S., Ch. 725.)

Sec. 1357.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 21.52G, Sec. 6, as added Acts 75th Leg., R.S., Ch. 725.)

CHAPTER 1358. DIABETES

SUBCHAPTER A. GUIDELINES FOR DIABETES CARE; MINIMUM COVERAGE REQUIRED

Sec. 1358.001. DEFINITION

Sec. 1358.002. APPLICABILITY OF SUBCHAPTER

Sec. 1358.003. EXCEPTION

Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS

Sec. 1358.005. COVERAGE REQUIRED

[Sections 1358.006-1358.050 reserved for expansion]

SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED WITH DIABETES TREATMENT

Sec. 1358.051. DEFINITIONS

Sec. 1358.052. APPLICABILITY OF SUBCHAPTER

Sec. 1358.053. EXCEPTION

Sec. 1358.054. COVERAGE REQUIRED

Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING

Sec. 1358.056. COVERAGE FOR NEW OR IMPROVED EQUIPMENT

AND SUPPLIES

Sec. 1358.057. RULES

CHAPTER 1358. DIABETES

SUBCHAPTER A. GUIDELINES FOR DIABETES CARE; MINIMUM

COVERAGE REQUIRED

Sec. 1358.001. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.53D, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 1285.)

Sec. 1358.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843;

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

1 (A) a multiple employer welfare arrangement as
2 defined by Section 3 of that Act; or

3 (B) another analogous benefit arrangement; and

4 (3) health and accident coverage provided by a risk
5 pool created under Chapter 172, Local Government Code,
6 notwithstanding Section 172.014, Local Government Code, or any
7 other law. (V.T.I.C. Art. 21.53D, Sec. 2(a), as added Acts 75th
8 Leg., R.S., Ch. 1285.)

9 Sec. 1358.003. EXCEPTION. This subchapter does not apply
10 to:

11 (1) a plan that provides coverage:

12 (A) only for a specified disease;

13 (B) only for accidental death or dismemberment;

14 (C) for wages or payments in lieu of wages for a
15 period during which an employee is absent from work because of
16 sickness or injury;

17 (D) as a supplement to a liability insurance
18 policy;

19 (E) only for dental or vision care; or

20 (F) only for indemnity for hospital confinement;

21 (2) a small employer health benefit plan written under
22 Chapter 1501;

23 (3) a Medicare supplemental policy as defined by
24 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

25 (4) a workers' compensation insurance policy;

26 (5) medical payment insurance coverage provided under
27 a motor vehicle insurance policy; or

1 (B) insulin pumps and associated appurtenances;
2 (C) insulin infusion devices; and
3 (D) podiatric appliances for the prevention of
4 complications associated with diabetes.

5 (2) "Diabetes supplies" means:

6 (A) test strips for blood glucose monitors;
7 (B) visual reading and urine test strips;
8 (C) lancets and lancet devices;
9 (D) insulin and insulin analogs;
10 (E) injection aids;
11 (F) syringes;
12 (G) prescriptive and nonprescriptive oral agents
13 for controlling blood sugar levels; and
14 (H) glucagon emergency kits.

15 (3) "Nutrition counseling" has the meaning assigned by
16 Section 701.002, Occupations Code.

17 (4) "Qualified enrollee" means an individual eligible
18 for coverage under a health benefit plan who has been diagnosed
19 with:

20 (A) insulin dependent or noninsulin dependent
21 diabetes;
22 (B) elevated blood glucose levels induced by
23 pregnancy; or
24 (C) another medical condition associated with
25 elevated blood glucose levels. (V.T.I.C. Art. 21.53G, Secs. 1(1),
26 (2), (4), (5).)

27 Sec. 1358.052. APPLICABILITY OF SUBCHAPTER. This

1 subchapter applies only to a health benefit plan that:

2 (1) provides benefits for medical or surgical expenses
3 incurred as a result of a health condition, accident, or sickness,
4 including:

5 (A) an individual, group, blanket, or franchise
6 insurance policy or insurance agreement, a group hospital service
7 contract, or an individual or group evidence of coverage that is
8 offered by:

9 (i) an insurance company;

10 (ii) a group hospital service corporation
11 operating under Chapter 842;

12 (iii) a fraternal benefit society operating
13 under Chapter 885;

14 (iv) a stipulated premium company operating
15 under Chapter 884;

16 (v) a reciprocal exchange operating under
17 Chapter 942; or

18 (vi) a health maintenance organization
19 operating under Chapter 843; and

20 (B) to the extent permitted by the Employee
21 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
22 seq.), a health benefit plan that is offered by a multiple employer
23 welfare arrangement as defined by Section 3 of that Act; or

24 (2) is offered by an approved nonprofit health
25 corporation that holds a certificate of authority under Chapter
26 844. (V.T.I.C. Art. 21.53G, Sec. 2(a).)

27 Sec. 1358.053. EXCEPTION. This subchapter does not apply

1 to:

2 (1) a plan that provides coverage:

3 (A) only for a specified disease or another
4 limited benefit;

5 (B) only for accidental death or dismemberment;

6 (C) for wages or payments in lieu of wages for a
7 period during which an employee is absent from work because of
8 sickness or injury;

9 (D) as a supplement to a liability insurance
10 policy;

11 (E) for credit insurance;

12 (F) only for dental or vision care; or

13 (G) only for indemnity for hospital confinement;

14 (2) a small employer health benefit plan written under
15 Chapter 1501;

16 (3) a Medicare supplemental policy as defined by
17 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

18 (4) a workers' compensation insurance policy;

19 (5) medical payment insurance coverage provided under
20 a motor vehicle insurance policy; or

21 (6) a long-term care insurance policy, including a
22 nursing home fixed indemnity policy, unless the commissioner
23 determines that the policy provides benefit coverage so
24 comprehensive that the policy is a health benefit plan as described
25 by Section 1358.052. (V.T.I.C. Art. 21.53G, Sec. 2(b).)

26 Sec. 1358.054. COVERAGE REQUIRED. (a) A health benefit
27 plan that provides coverage for the treatment of diabetes and

1 conditions associated with diabetes must provide to each qualified
2 enrollee coverage for:

- 3 (1) diabetes equipment;
- 4 (2) diabetes supplies; and
- 5 (3) diabetes self-management training in accordance
6 with the requirements of Section 1358.055.

7 (b) A health benefit plan may require a deductible,
8 copayment, or coinsurance for coverage provided under this section.
9 The amount of the deductible, copayment, or coinsurance may not
10 exceed the amount of the deductible, copayment, or coinsurance
11 required for treatment of other analogous chronic medical
12 conditions. (V.T.I.C. Art. 21.53G, Secs. 3, 6.)

13 Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING. (a)
14 Diabetes self-management training must be provided by a health care
15 practitioner or provider who is:

- 16 (1) licensed, registered, or certified in this state
17 to provide appropriate health care services; and
- 18 (2) acting within the scope of practice authorized by
19 the license, registration, or certification.

20 (b) For purposes of this subchapter, "self-management
21 training" includes:

- 22 (1) training provided to a qualified enrollee, after
23 the initial diagnosis of diabetes, in the care and management of
24 that condition, including nutrition counseling and counseling on
25 the proper use of diabetes equipment and supplies;

- 26 (2) additional training authorized on the diagnosis of
27 a physician or other health care practitioner of a significant

1 change in the qualified enrollee's symptoms or condition that
2 requires changes in the qualified enrollee's self-management
3 regime; and

4 (3) periodic or episodic continuing education
5 training prescribed by an appropriate health care practitioner as
6 warranted by the development of new techniques or treatments for
7 diabetes.

8 (c) If the diabetes self-management training is provided on
9 the written order of a physician or other health care practitioner,
10 including a health care practitioner practicing under protocols
11 jointly developed with a physician, the training must also include:

12 (1) a diabetes self-management training program
13 recognized by the American Diabetes Association;

14 (2) diabetes self-management training provided by a
15 multidisciplinary team:

16 (A) the nonphysician members of which are
17 coordinated by:

18 (i) a diabetes educator who is certified by
19 the National Certification Board for Diabetes Educators; or

20 (ii) an individual who has completed at
21 least 24 hours of continuing education that meets guidelines
22 established by the Texas Board of Health and that includes a
23 combination of diabetes-related educational principles and
24 behavioral strategies;

25 (B) that consists of at least a licensed
26 dietitian and a registered nurse and may include a pharmacist and a
27 social worker; and

1 (C) each member of which, other than a social
2 worker, has recent didactic and experiential preparation in
3 diabetes clinical and educational issues as determined by the
4 member's licensing agency, in consultation with the commissioner of
5 public health, unless the member's licensing agency, in
6 consultation with the commissioner of public health, determines
7 that the core educational preparation for the member's license
8 includes the skills the member needs to provide diabetes
9 self-management training;

10 (3) diabetes self-management training provided by a
11 diabetes educator certified by the National Certification Board for
12 Diabetes Educators; or

13 (4) diabetes self-management training that provides
14 one or more of the following components:

15 (A) a nutrition counseling component provided by
16 a licensed dietitian, for which the licensed dietitian shall be
17 paid;

18 (B) a pharmaceutical component provided by a
19 pharmacist, for which the pharmacist shall be paid;

20 (C) a component provided by a physician assistant
21 or registered nurse, for which the physician assistant or
22 registered nurse shall be paid, except that the physician assistant
23 or registered nurse may not be paid for providing a nutrition
24 counseling or pharmaceutical component unless a licensed dietitian
25 or pharmacist is unavailable to provide that component; or

26 (D) a component provided by a physician.

27 (d) An individual may not provide a component of diabetes

1 self-management training under Subsection (c)(4) unless:

2 (1) the subject matter of the component is within the
3 scope of the individual's practice; and

4 (2) the individual meets the education requirements,
5 as determined by the individual's licensing agency in consultation
6 with the commissioner of public health. (V.T.I.C. Art. 21.53G,
7 Sec. 4.)

8 Sec. 1358.056. COVERAGE FOR NEW OR IMPROVED EQUIPMENT AND
9 SUPPLIES. A health benefit plan must provide coverage for new or
10 improved diabetes equipment or supplies, including improved
11 insulin or another prescription drug, approved by the United States
12 Food and Drug Administration if the equipment or supplies are
13 determined by a physician or other health care practitioner to be
14 medically necessary and appropriate. (V.T.I.C. Art. 21.53G, Sec.
15 5.)

16 Sec. 1358.057. RULES. (a) The commissioner shall adopt
17 rules necessary to implement this subchapter.

18 (b) In adopting rules under this section, the commissioner
19 may consult with the commissioner of public health and other
20 appropriate entities. (V.T.I.C. Art. 21.53G, Sec. 7.)

21 CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH PHENYLKETONURIA

22 OR OTHER HERITABLE DISEASES

23 Sec. 1359.001. DEFINITIONS

24 Sec. 1359.002. APPLICABILITY OF CHAPTER

25 Sec. 1359.003. COVERAGE REQUIRED

26 CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH PHENYLKETONURIA

27 OR OTHER HERITABLE DISEASES

1 Sec. 1359.001. DEFINITIONS. In this chapter:

2 (1) "Heritable disease" means an inherited disease
3 that may result in mental or physical retardation or death.

4 (2) "Phenylketonuria" means an inherited condition
5 that, if not treated, may cause severe mental retardation.
6 (V.T.I.C. Art. 3.79, Secs. 1(2), (3).)

7 Sec. 1359.002. APPLICABILITY OF CHAPTER. This chapter
8 applies only to a group health benefit plan that is a group policy,
9 contract, or certificate of health insurance or an evidence of
10 coverage delivered, issued for delivery, or renewed in this state
11 by:

12 (1) an insurance company;

13 (2) a group hospital service corporation operating
14 under Chapter 842; or

15 (3) a health maintenance organization operating under
16 Chapter 843. (V.T.I.C. Art. 3.79, Sec. 1(1).)

17 Sec. 1359.003. COVERAGE REQUIRED. (a) A group health
18 benefit plan must provide coverage for formulas necessary to treat
19 phenylketonuria or a heritable disease.

20 (b) The group health benefit plan must provide the coverage
21 to the same extent that the plan provides coverage for drugs that
22 are available only on the orders of a physician. (V.T.I.C. Art.
23 3.79, Sec. 2.)

24 CHAPTER 1360. DIAGNOSIS AND TREATMENT AFFECTING
25 TEMPOROMANDIBULAR JOINT

26 Sec. 1360.001. DEFINITION

27 Sec. 1360.002. APPLICABILITY OF CHAPTER

1 Sec. 1360.003. EXCEPTION

2 Sec. 1360.004. COVERAGE REQUIRED

3 Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED

4 CHAPTER 1360. DIAGNOSIS AND TREATMENT AFFECTING
5 TEMPOROMANDIBULAR JOINT

6 Sec. 1360.001. DEFINITION. In this chapter,
7 "temporomandibular joint" includes the jaw and the
8 craniomandibular joint. (V.T.I.C. Art. 21.53A, Sec. 3(a) (part).)

9 Sec. 1360.002. APPLICABILITY OF CHAPTER. This chapter
10 applies only to a group health benefit plan delivered or issued for
11 delivery in this state that:

12 (1) provides benefits for dental, medical, or surgical
13 expenses incurred as a result of a health condition, accident, or
14 sickness, including:

15 (A) a group, blanket, or franchise insurance
16 policy or insurance agreement, a group hospital service contract,
17 or a group evidence of coverage that is offered by:

18 (i) an insurance company;
19 (ii) a group hospital service corporation
20 operating under Chapter 842;

21 (iii) a fraternal benefit society operating
22 under Chapter 885;

23 (iv) a stipulated premium company operating
24 under Chapter 884; or

25 (v) a health maintenance organization
26 operating under Chapter 843; and

27 (B) to the extent permitted by the Employee

1 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
2 seq.), a health benefit plan that is offered by:

3 (i) a multiple employer welfare arrangement
4 as defined by Section 3 of that Act;

5 (ii) an entity not authorized under this
6 code or another insurance law of this state that contracts directly
7 for health care services on a risk-sharing basis, including a
8 capitation basis; or

9 (iii) another analogous benefit
10 arrangement; or

11 (2) is offered by an approved nonprofit health
12 corporation that holds a certificate of authority under Chapter
13 844. (V.T.I.C. Art. 21.53A, Secs. 2(a), 3(a) (part).)

14 Sec. 1360.003. EXCEPTION. This chapter does not apply to:

15 (1) a plan that provides coverage:

16 (A) only for a specified disease or another
17 limited benefit;

18 (B) only for accidental death or dismemberment;

19 (C) for wages or payments in lieu of wages for a
20 period during which an employee is absent from work because of
21 sickness or injury;

22 (D) as a supplement to a liability insurance
23 policy;

24 (E) for credit insurance;

25 (F) only for vision care; or

26 (G) only for indemnity for hospital confinement;

27 (2) a Medicare supplemental policy as defined by

1 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

2 (3) a workers' compensation insurance policy;

3 (4) a small employer health benefit plan written under
4 Chapter 1501;

5 (5) medical payment insurance coverage provided under
6 a motor vehicle insurance policy; or

7 (6) a long-term care insurance policy, including a
8 nursing home fixed indemnity policy, unless the commissioner
9 determines that the policy provides benefit coverage so
10 comprehensive that the policy is a health benefit plan as described
11 by Section 1360.002. (V.T.I.C. Art. 21.53A, Sec. 2(b).)

12 Sec. 1360.004. COVERAGE REQUIRED. (a) A health benefit
13 plan that provides coverage for medically necessary diagnostic or
14 surgical treatment of conditions affecting skeletal joints must
15 provide comparable coverage for diagnostic or surgical treatment of
16 conditions affecting the temporomandibular joint if the treatment
17 is medically necessary as a result of:

18 (1) an accident;

19 (2) a trauma;

20 (3) a congenital defect;

21 (4) a developmental defect; or

22 (5) a pathology.

23 (b) Coverage required under this section may be subject to
24 any provision in the health benefit plan that is generally
25 applicable to surgical treatment, including a requirement for
26 precertification of coverage. (V.T.I.C. Art. 21.53A, Secs. 3(a)
27 (part), (b), (c).)

1 Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED. (a)
2 This chapter does not require a health benefit plan to provide
3 coverage for dental services if dental services are not otherwise
4 scheduled or provided as part of the coverage provided under the
5 plan.

6 (b) A health benefit plan may not exclude from coverage
7 under the plan an individual who is unable to undergo dental
8 treatment in an office setting or under local anesthesia due to a
9 documented physical, mental, or medical reason as determined by the
10 individual's physician or by the dentist providing the dental care.
11 (V.T.I.C. Art. 21.53A, Sec. 4.)

12 CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

13 Sec. 1361.001. DEFINITION

14 Sec. 1361.002. APPLICABILITY OF CHAPTER

15 Sec. 1361.003. COVERAGE REQUIRED

16 CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

17 Sec. 1361.001. DEFINITION. In this chapter, "qualified
18 enrollee" means an individual entitled to coverage under a group
19 health benefit plan who is:

20 (1) a postmenopausal woman who is not receiving
21 estrogen replacement therapy;

22 (2) an individual with:

23 (A) vertebral abnormalities;

24 (B) primary hyperparathyroidism; or

25 (C) a history of bone fractures; or

26 (3) an individual who is:

27 (A) receiving long-term glucocorticoid therapy;

1 or

2 (B) being monitored to assess the response to or
3 efficacy of an approved osteoporosis drug therapy. (V.T.I.C. Art.
4 21.53C, Secs. (b), (c) (part).)

5 Sec. 1361.002. APPLICABILITY OF CHAPTER. This chapter
6 applies only to a group health benefit plan delivered, issued for
7 delivery, or renewed in this state that provides coverage for
8 medical or surgical expenses incurred as a result of accident or
9 sickness, including:

10 (1) a group insurance policy;

11 (2) a group contract issued by a group hospital
12 service corporation operating under Chapter 842; and

13 (3) a group contract issued by a health maintenance
14 organization operating under Chapter 843. (V.T.I.C. Art. 21.53C,
15 Sec. (a).)

16 Sec. 1361.003. COVERAGE REQUIRED. A group health benefit
17 plan must provide to a qualified enrollee coverage for medically
18 accepted bone mass measurement to detect low bone mass and to
19 determine the enrollee's risk of osteoporosis and fractures
20 associated with osteoporosis. (V.T.I.C. Art. 21.53C, Sec. (c)
21 (part).)

22 CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

23 Sec. 1362.001. APPLICABILITY OF CHAPTER

24 Sec. 1362.002. EXCEPTION

25 Sec. 1362.003. COVERAGE REQUIRED

26 Sec. 1362.004. NOTICE OF COVERAGE

27 Sec. 1362.005. RULES

CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

Sec. 1362.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by:

1 (A) an approved nonprofit health corporation
2 that holds a certificate of authority under Chapter 844; or

3 (B) an entity not authorized under this code or
4 another insurance law of this state that contracts directly for
5 health care services on a risk-sharing basis, including a
6 capitation basis; or

7 (3) provides health and accident coverage through a
8 risk pool created under Chapter 172, Local Government Code,
9 notwithstanding Section 172.014, Local Government Code, or any
10 other law. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th
11 Leg., R.S., Ch. 1287.)

12 Sec. 1362.002. EXCEPTION. This chapter does not apply to:

13 (1) a health benefit plan that provides coverage:

14 (A) only for a specified disease or for another
15 limited benefit;

16 (B) only for accidental death or dismemberment;

17 (C) for wages or payments in lieu of wages for a
18 period during which an employee is absent from work because of
19 sickness or injury;

20 (D) as a supplement to a liability insurance
21 policy; or

22 (E) only for indemnity for hospital confinement;

23 (2) a small employer health benefit plan written under
24 Chapter 1501;

25 (3) a Medicare supplemental policy as defined by
26 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

27 (4) a workers' compensation insurance policy;

1 (5) medical payment insurance coverage provided under
2 a motor vehicle insurance policy; or

3 (6) a long-term care insurance policy, including a
4 nursing home fixed indemnity policy, unless the commissioner
5 determines that the policy provides benefit coverage so
6 comprehensive that the policy is a health benefit plan as described
7 by Section 1362.001. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added
8 Acts 75th Leg., R.S., Ch. 1287.)

9 Sec. 1362.003. COVERAGE REQUIRED. (a) A health benefit
10 plan that provides coverage for diagnostic medical procedures must
11 provide to each male enrolled in the plan coverage for expenses for
12 an annual medically recognized diagnostic examination for the
13 detection of prostate cancer.

14 (b) Coverage required under this section includes at a
15 minimum:

16 (1) a physical examination for the detection of
17 prostate cancer; and

18 (2) a prostate-specific antigen test used for the
19 detection of prostate cancer for each male who:

20 (A) is at least 50 years of age and is
21 asymptomatic; or

22 (B) is at least 40 years of age and has a family
23 history of prostate cancer or another prostate cancer risk factor.
24 (V.T.I.C. Art. 21.53F, Sec. 3, as added Acts 75th Leg., R.S., Ch.
25 1287.)

26 Sec. 1362.004. NOTICE OF COVERAGE. (a) A health benefit
27 plan issuer shall provide to each individual enrolled in the plan

1 written notice of the coverage required under this chapter.

2 (b) The notice must be provided in accordance with rules
3 adopted by the commissioner. (V.T.I.C. Art. 21.53F, Sec. 4, as
4 added Acts 75th Leg., R.S., Ch. 1287.)

5 Sec. 1362.005. RULES. The commissioner shall adopt rules
6 necessary to administer this chapter. (V.T.I.C. Art. 21.53F, Sec.
7 5, as added Acts 75th Leg., R.S., Ch. 1287.)

8 CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF
9 COLORECTAL CANCER

10 Sec. 1363.001. APPLICABILITY OF CHAPTER

11 Sec. 1363.002. EXCEPTION

12 Sec. 1363.003. MINIMUM COVERAGE REQUIRED

13 Sec. 1363.004. NOTICE OF COVERAGE

14 Sec. 1363.005. RULES

15 CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF
16 COLORECTAL CANCER

17 Sec. 1363.001. APPLICABILITY OF CHAPTER. This chapter
18 applies only to a health benefit plan that:

19 (1) provides benefits for medical or surgical expenses
20 incurred as a result of a health condition, accident, or sickness,
21 including:

22 (A) an individual, group, blanket, or franchise
23 insurance policy or insurance agreement, a group hospital service
24 contract, or an individual or group evidence of coverage that is
25 offered by:

26 (i) an insurance company;

27 (ii) a group hospital service corporation

operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a Lloyd's plan operating under Chapter 941;

(v) a stipulated premium company operating under Chapter 884; or

(vi) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation operating under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53S, Sec. 2(a).)

Sec. 1363.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

1 (C) for wages or payments in lieu of wages for a
2 period during which an employee is absent from work because of
3 sickness or injury;

4 (D) as a supplement to a liability insurance
5 policy; or

6 (E) only for indemnity for hospital confinement;

7 (2) a small employer health benefit plan written under
8 Chapter 1501;

9 (3) a Medicare supplemental policy as defined by
10 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
11 as amended;

12 (4) a workers' compensation insurance policy;

13 (5) medical payment insurance coverage provided under
14 a motor vehicle insurance policy; or

15 (6) a long-term care policy, including a nursing home
16 fixed indemnity policy, unless the commissioner determines that the
17 policy provides benefit coverage so comprehensive that the policy
18 is a health benefit plan as described by Section 1363.001.
19 (V.T.I.C. Art. 21.53S, Sec. 2(b).)

20 Sec. 1363.003. MINIMUM COVERAGE REQUIRED. (a) A health
21 benefit plan that provides coverage for screening medical
22 procedures must provide to each individual enrolled in the plan who
23 is 50 years of age or older and at normal risk for developing colon
24 cancer coverage for expenses incurred in conducting a medically
25 recognized screening examination for the detection of colorectal
26 cancer.

27 (b) The minimum coverage required under this section must

1 include:

2 (1) a fecal occult blood test performed annually and a
3 flexible sigmoidoscopy performed every five years; or

4 (2) a colonoscopy performed every 10 years. (V.T.I.C.
5 Art. 21.53S, Sec. 3.)

6 Sec. 1363.004. NOTICE OF COVERAGE. (a) A health benefit
7 plan issuer shall provide to each individual enrolled in the plan
8 written notice of the coverage required under this chapter.

9 (b) The notice must be provided in accordance with rules
10 adopted by the commissioner. (V.T.I.C. Art. 21.53S, Sec. 4.)

11 Sec. 1363.005. RULES. The commissioner shall adopt rules
12 as necessary to administer this chapter. (V.T.I.C. Art. 21.53S,
13 Sec. 5.)

14 CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV,
15 AIDS, OR HIV-RELATED ILLNESSES

16 SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

17 Sec. 1364.001. APPLICABILITY OF SUBCHAPTER

18 Sec. 1364.002. EXCEPTION

19 Sec. 1364.003. PROHIBITION

20 Sec. 1364.004. RULES

21 [Sections 1364.005-1364.050 reserved for expansion]

22 SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

23 Sec. 1364.051. DEFINITIONS

24 Sec. 1364.052. APPLICABILITY OF SUBCHAPTER

25 Sec. 1364.053. PROHIBITION

26 [Sections 1364.054-1364.100 reserved for expansion]

27 SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL

GOVERNMENTS

Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION
OF COVERAGES

CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV,
AIDS, OR HIV-RELATED ILLNESSES

SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

Sec. 1364.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that is delivered, issued for delivery, or renewed and that is:

- (1) a group accident and health insurance policy;
- (2) a group contract issued by a group hospital service corporation operating under Chapter 842; or
- (3) a group evidence of coverage issued by a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.51-6, Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

Sec. 1364.002. EXCEPTION. This subchapter does not apply to:

- (1) a credit accident and health insurance policy subject to Chapter 1153;
- (2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;
- (3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the department; or

1 (4) any policy or contract of insurance with a state
2 agency, department, or board providing health services:

3 (A) to eligible individuals under Chapter 32,
4 Human Resources Code; or

5 (B) under a state plan adopted in accordance with
6 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section
7 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

8 Sec. 1364.003. PROHIBITION. A group health benefit plan
9 may not exclude or deny coverage for:

10 (1) human immunodeficiency virus (HIV);

11 (2) acquired immune deficiency syndrome (AIDS); or

12 (3) an HIV-related illness. (V.T.I.C. Art. 3.51-6,
13 Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

14 Sec. 1364.004. RULES. The commissioner may adopt rules
15 necessary to administer this subchapter. A rule adopted under this
16 section is subject to notice and hearing as provided by Section
17 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art.
18 3.51-6, Sec. 5.)

19 [Sections 1364.005-1364.050 reserved for expansion]

20 SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

21 Sec. 1364.051. DEFINITIONS. In this subchapter, "AIDS" and
22 "HIV" have the meanings assigned by Section 81.101, Health and
23 Safety Code. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

24 Sec. 1364.052. APPLICABILITY OF SUBCHAPTER. This
25 subchapter applies to an insurer that delivers or issues for
26 delivery a group health insurance policy or contract in this state,
27 including a group hospital service corporation operating under

Chapter 842. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

Sec. 1364.053. PROHIBITION. (a) Except as provided by Subsection (b), an insurer may not cancel during the term of a group health insurance policy or contract an individual's coverage provided by the policy or contract because the individual:

(1) has been diagnosed as having AIDS or HIV;

(2) has been treated for AIDS or HIV; or

(3) is being treated for AIDS or HIV.

(b) The insurer may cancel the coverage provided by the policy or contract for fraud or misrepresentation in the obtaining of coverage by failure to disclose a diagnosis of AIDS or an HIV-related condition. (V.T.I.C. Art. 3.51-6D, Subsecs. (a) (part), (b).)

[Sections 1364.054-1364.100 reserved for expansion]

SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL
GOVERNMENTS

Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION OF COVERAGES. A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that excludes or limits coverage or services for:

(1) acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service; or

(2) human immunodeficiency virus infection.

(V.T.I.C. Art. 3.51-5A, Subsec. (a) (part).)

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

Sec. 1365.001. APPLICABILITY OF CHAPTER

Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS

OF OTHER LAW

Sec. 1365.003. OFFER OF COVERAGE REQUIRED

Sec. 1365.004. RIGHT TO REJECT COVERAGE OR SELECT

ALTERNATIVE COVERAGE

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

Sec. 1365.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that provides hospital and medical coverage on an expense-incurred, service, or prepaid basis, including a group policy, contract, or plan that is offered in this state by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842; or

(3) a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Sec. 1365.003. OFFER OF COVERAGE REQUIRED. (a) A group health benefit plan issuer shall offer and make available under the plan coverage for the necessary care and treatment of loss or

1 impairment of speech or hearing.

2 (b) Coverage required under this section:

3 (1) may not be less favorable than coverage for
4 physical illness generally under the plan; and

5 (2) must be subject to the same durational limits,
6 dollar limits, deductibles, and coinsurance factors as coverage for
7 physical illness generally under the plan. (V.T.I.C. Art. 3.70-2,
8 Sec. (G) (part).)

9 Sec. 1365.004. RIGHT TO REJECT COVERAGE OR SELECT
10 ALTERNATIVE COVERAGE. An offer of coverage required under Section
11 1365.003 is subject to the right of the group contract holder to
12 reject the coverage or to select an alternative level of coverage
13 that is offered by or negotiated with the group health benefit plan
14 issuer. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

15 CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

16 SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

17 Sec. 1366.001. APPLICABILITY OF SUBCHAPTER

18 Sec. 1366.002. EXCEPTION

19 Sec. 1366.003. OFFER OF COVERAGE REQUIRED

20 Sec. 1366.004. REJECTION OF OFFER

21 Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE

22 Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT
23 REQUIRED TO OFFER COVERAGE

24 Sec. 1366.007. RULES

25 [Sections 1366.008-1366.050 reserved for expansion]

26 SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH
27 OF CHILD AND POSTDELIVERY CARE

1 Sec. 1366.051. SHORT TITLE

2 Sec. 1366.052. DEFINITIONS

3 Sec. 1366.053. APPLICABILITY OF SUBCHAPTER

4 Sec. 1366.054. EXCEPTION

5 Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED

6 Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED

7 Sec. 1366.057. PROHIBITED CONDUCT

8 Sec. 1366.058. NOTICE OF COVERAGE

9 Sec. 1366.059. RULES

10 CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

11 SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

12 Sec. 1366.001. APPLICABILITY OF SUBCHAPTER. This
13 subchapter applies only to a group health benefit plan that
14 provides benefits for hospital, medical, or surgical expenses
15 incurred as a result of accident or sickness, including a group
16 health insurance policy, health care service contract or plan, or
17 other provision of group health benefits, coverage, or services in
18 this state that is issued, entered into, or provided by:

19 (1) an insurer;

20 (2) a group hospital service corporation operating
21 under Chapter 842;

22 (3) a health maintenance organization operating under
23 Chapter 843; or

24 (4) an employer, multiple employer, union,
25 association, trustee, or other self-funded or self-insured welfare
26 or benefit plan, program, or arrangement. (V.T.I.C. Art. 3.51-6,
27 Sec. 3A(a) (part).)

1 Sec. 1366.002. EXCEPTION. This subchapter does not apply
2 to:

3 (1) a credit accident and health insurance policy
4 subject to Chapter 1153;

5 (2) any group specifically provided for or authorized
6 by law in existence and covered under a policy filed with the State
7 Board of Insurance before April 1, 1975;

8 (3) accident and health coverages that are incidental
9 to any form of a group automobile, casualty, property, workers'
10 compensation, or employers' liability policy approved by the
11 commissioner; or

12 (4) any policy or contract of insurance with a state
13 agency, department, or board providing health services:

14 (A) to eligible individuals under Chapter 32,
15 Human Resources Code; or

16 (B) under a state plan adopted in accordance with
17 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section
18 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

19 Sec. 1366.003. OFFER OF COVERAGE REQUIRED. (a) Subject to
20 this subchapter, an issuer of a group health benefit plan that
21 provides pregnancy-related benefits for individuals covered under
22 the plan shall offer and make available to each holder or sponsor of
23 the plan coverage for services and benefits on an expense incurred,
24 service, or prepaid basis for outpatient expenses that arise from
25 in vitro fertilization procedures.

26 (b) Benefits for in vitro fertilization procedures required
27 under this section must be provided to the same extent as benefits

1 provided for other pregnancy-related procedures under the plan.
2 (V.T.I.C. Art. 3.51-6, Secs. 3A(a) (part), (b), (d).)

3 Sec. 1366.004. REJECTION OF OFFER. A rejection of an offer
4 under Section 1366.003 to provide coverage for in vitro
5 fertilization procedures must be in writing. (V.T.I.C. Art.
6 3.51-6, Sec. 3A(c).)

7 Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE. The
8 coverage offered under Section 1366.003 is required only if:

9 (1) the patient for the in vitro fertilization
10 procedure is an individual covered under the group health benefit
11 plan;

12 (2) the fertilization or attempted fertilization of
13 the patient's oocytes is made only with the sperm of the patient's
14 spouse;

15 (3) the patient and the patient's spouse have a history
16 of infertility of at least five continuous years' duration or the
17 infertility is associated with:

18 (A) endometriosis;

19 (B) exposure in utero to diethylstilbestrol
20 (DES);

21 (C) blockage of or surgical removal of one or
22 both fallopian tubes; or

23 (D) oligospermia;

24 (4) the patient has been unable to attain a successful
25 pregnancy through any less costly applicable infertility
26 treatments for which coverage is available under the group health
27 benefit plan; and

1 (5) the in vitro fertilization procedures are
2 performed at a medical facility that conforms to the minimal
3 standards for programs of in vitro fertilization adopted by the
4 American Society for Reproductive Medicine. (V.T.I.C. Art. 3.51-6,
5 Sec. 3A(e).)

6 Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT
7 REQUIRED TO OFFER COVERAGE. An insurer, health maintenance
8 organization, or self-insuring employer that is owned by or that is
9 part of an entity, group, or order that is directly affiliated with
10 a bona fide religious denomination that includes as an integral
11 part of its beliefs and practices that in vitro fertilization is
12 contrary to moral principles that the religious denomination
13 considers to be an essential part of its beliefs is not required to
14 offer coverage for in vitro fertilization under Section 1366.003.
15 (V.T.I.C. Art. 3.51-6, Sec. 3A(f).)

16 Sec. 1366.007. RULES. The commissioner may adopt rules
17 necessary to administer this subchapter. A rule adopted under this
18 section is subject to notice and hearing as provided by Section
19 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art.
20 3.51-6, Sec. 5.)

21 [Sections 1366.008-1366.050 reserved for expansion]

22 SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH
23 OF CHILD AND POSTDELIVERY CARE

24 Sec. 1366.051. SHORT TITLE. This subchapter may be cited as
25 the Lee Alexandria Hanley Act. (V.T.I.C. Art. 21.53F, Sec. 1, as
26 added Acts 75th Leg., R.S., Ch. 832.)

27 Sec. 1366.052. DEFINITIONS. In this subchapter:

1 (1) "Attending physician" means an obstetrician,
2 pediatrician, or other physician who attends a woman who has given
3 birth to a child or who attends a newborn child.

4 (2) "Postdelivery care" means postpartum health care
5 services provided in accordance with accepted maternal and neonatal
6 physical assessments. The term includes parent education,
7 assistance and training in breast-feeding and bottle-feeding, and
8 the performance of any necessary and appropriate clinical tests.
9 (V.T.I.C. Art. 21.53F, Secs. 2(1), 5(c) (part), as added Acts 75th
10 Leg., R.S., Ch. 832.)

11 Sec. 1366.053. APPLICABILITY OF SUBCHAPTER. This
12 subchapter applies only to a health benefit plan that:

13 (1) provides benefits for medical or surgical expenses
14 incurred as a result of a health condition, accident, or sickness,
15 including:

16 (A) an individual, group, blanket, or franchise
17 insurance policy or insurance agreement, a group hospital service
18 contract, or an individual or group evidence of coverage that is
19 offered by:

20 (i) an insurance company;
21 (ii) a group hospital service corporation
22 operating under Chapter 842;

23 (iii) a fraternal benefit society operating
24 under Chapter 885;

25 (iv) a stipulated premium company operating
26 under Chapter 884; or

27 (v) a health maintenance organization

operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53F, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.054. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1366.053. (V.T.I.C. Art. 21.53F, Sec. 3(b), as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED. (a) Except as provided by Subsection (b), a health benefit plan that provides maternity benefits, including benefits for childbirth, must provide to a woman who has given birth to a child and the newborn child coverage for inpatient care in a health care facility for not less than:

(1) 48 hours after an uncomplicated vaginal delivery;

and

(2) 96 hours after an uncomplicated delivery by cesarean section.

(b) A health benefit plan that provides to a woman who has given birth to a child and the newborn child coverage for in-home postdelivery care is not required to provide the coverage required

1 under Subsection (a) unless:

2 (1) the attending physician determines that inpatient
3 care is medically necessary; or

4 (2) the woman requests inpatient care.

5 (c) For purposes of Subsection (a), the attending physician
6 shall determine whether a delivery is complicated.

7 (d) This section does not require a woman who is eligible
8 for coverage under a health benefit plan to:

9 (1) give birth to a child in a hospital or other health
10 care facility; or

11 (2) remain under inpatient care in a hospital or other
12 health care facility for any fixed term following the birth of a
13 child. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg.,
14 R.S., Ch. 832.)

15 Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED.

16 (a) If a decision is made to discharge a woman who has given birth
17 to a child or the newborn child from inpatient care before the
18 expiration of the minimum hours of coverage required under Section
19 1366.055(a), a health benefit plan must provide to the woman and
20 child coverage for timely postdelivery care.

21 (b) The timeliness of the postdelivery care shall be
22 determined in accordance with recognized medical standards for that
23 care.

24 (c) The postdelivery care may be provided by a physician,
25 registered nurse, or other appropriate licensed health care
26 provider.

27 (d) Subject to Subsection (e), the postdelivery care may be

provided at:

- (1) the woman's home;
- (2) a health care provider's office;
- (3) a health care facility; or
- (4) another location determined to be appropriate under rules adopted by the commissioner.

(e) The coverage required under this section must give the woman the option to have the care provided in the woman's home. (V.T.I.C. Art. 21.53F, Secs. 5(a), (b), (c) (part), as added Acts 75th Leg., R.S., Ch. 832.)

Sec. 1366.057. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

(1) modify the terms and conditions of coverage based on a request by an enrollee for less than the minimum coverage required under Section 1366.055(a);

(2) offer to a woman who has given birth to a child a financial incentive or other compensation the receipt of which is contingent on the waiver by the woman of the minimum coverage required under Section 1366.055(a);

(3) refuse to accept a physician's recommendation for inpatient care made in consultation with the woman who has given birth to a child if the period of inpatient care recommended by the physician does not exceed the minimum periods recommended in guidelines for perinatal care developed by:

(A) the American College of Obstetricians and Gynecologists;

(B) the American Academy of Pediatrics; or

1 (C) another nationally recognized professional
2 association of obstetricians and gynecologists or of
3 pediatricians;

4 (4) reduce payments or other forms of reimbursement
5 for inpatient care below the usual and customary rate of
6 reimbursement for that care; or

7 (5) penalize a physician for recommending inpatient
8 care for a woman or the woman's newborn child by:

9 (A) refusing to permit the physician to
10 participate as a provider in the health benefit plan;

11 (B) reducing payments made to the physician;

12 (C) requiring the physician to:

13 (i) provide additional documentation; or

14 (ii) undergo additional utilization
15 review; or

16 (D) imposing other analogous sanctions or
17 disincentives. (V.T.I.C. Art. 21.53F, Sec. 6, as added Acts 75th
18 Leg., R.S., Ch. 832.)

19 Sec. 1366.058. NOTICE OF COVERAGE. (a) An issuer of a
20 health benefit plan shall provide to each individual enrolled in
21 the plan written notice of the coverage required under this
22 subchapter.

23 (b) The notice must be provided in accordance with rules
24 adopted by the commissioner. (V.T.I.C. Art. 21.53F, Secs. 2(2), 7,
25 as added Acts 75th Leg., R.S., Ch. 832.)

26 Sec. 1366.059. RULES. The commissioner shall adopt rules
27 necessary to administer this subchapter. (V.T.I.C. Art. 21.53F,

1 Sec. 8, as added Acts 75th Leg., R.S., Ch. 832.)

2 CHAPTER 1367. COVERAGE OF CHILDREN

3 SUBCHAPTER A. NEWBORN CHILDREN

4 Sec. 1367.001. APPLICABILITY OF SUBCHAPTER

5 Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS

6 OF OTHER LAW

7 Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN

8 CHILDREN PROHIBITED

9 [Sections 1367.004-1367.050 reserved for expansion]

10 SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

11 Sec. 1367.051. APPLICABILITY OF SUBCHAPTER

12 Sec. 1367.052. EXCEPTION

13 Sec. 1367.053. COVERAGE REQUIRED

14 Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE

15 REQUIREMENT PROHIBITED

16 Sec. 1367.055. RULES

17 [Sections 1367.056-1367.100 reserved for expansion]

18 SUBCHAPTER C. HEARING TEST

19 Sec. 1367.101. APPLICABILITY OF SUBCHAPTER

20 Sec. 1367.102. EXCEPTION

21 Sec. 1367.103. COVERAGE REQUIRED

22 Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT PERMITTED;

23 DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT

24 PROHIBITED; NOTICE REQUIRED

25 Sec. 1367.105. RULES

26 [Sections 1367.106-1367.150 reserved for expansion]

27 SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

1 Sec. 1367.151. APPLICABILITY OF SUBCHAPTER

2 Sec. 1367.152. EXCEPTION

3 Sec. 1367.153. RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL

4 ABNORMALITIES; DEFINITION REQUIRED

5 Sec. 1367.154. RULES

6 CHAPTER 1367. COVERAGE OF CHILDREN

7 SUBCHAPTER A. NEWBORN CHILDREN

8 Sec. 1367.001. APPLICABILITY OF SUBCHAPTER. This
9 subchapter applies only to a health benefit plan delivered or
10 issued for delivery in this state that is an individual or group
11 policy of accident and health insurance, including a policy issued
12 by a group hospital service corporation operating under Chapter
13 842. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

14 Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
15 LAW. The provisions of Chapter 1201, including provisions relating
16 to the applicability, purpose, and enforcement of that chapter,
17 construction of policies under that chapter, rulemaking under that
18 chapter, and definitions of terms applicable in that chapter, apply
19 to this subchapter. (New.)

20 Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN
21 CHILDREN PROHIBITED. A health benefit plan that provides maternity
22 benefits or accident and health coverage for additional newborn
23 children may not be issued in this state if the plan excludes or
24 limits:

25 (1) initial coverage of a newborn child for a period of
26 time; or

27 (2) coverage for congenital defects of a newborn

1 child. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

2 [Sections 1367.004-1367.050 reserved for expansion]

3 SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

4 Sec. 1367.051. APPLICABILITY OF SUBCHAPTER. This
5 subchapter applies only to a health benefit plan that:

6 (1) provides benefits for medical or surgical expenses
7 incurred as a result of a health condition, accident, or sickness,
8 including an individual, group, blanket, or franchise insurance
9 policy or insurance agreement, a group hospital service contract,
10 or an individual or group evidence of coverage that is offered by:

11 (A) an insurance company;

12 (B) a group hospital service corporation
13 operating under Chapter 842;

14 (C) a fraternal benefit society operating under
15 Chapter 885;

16 (D) a stipulated premium company operating under
17 Chapter 884;

18 (E) a health maintenance organization operating
19 under Chapter 843; or

20 (F) a multiple employer welfare arrangement
21 subject to regulation under Chapter 846;

22 (2) is offered by an approved nonprofit health
23 corporation that holds a certificate of authority under Chapter
24 844; or

25 (3) provides health and accident coverage through a
26 risk pool created under Chapter 172, Local Government Code,
27 notwithstanding Section 172.014, Local Government Code, or any

1 other law. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), as added Acts
2 75th Leg., R.S., Ch. 683.)

3 Sec. 1367.052. EXCEPTION. This subchapter does not apply
4 to:

5 (1) a plan that provides coverage:

6 (A) only for a specified disease or for another
7 limited benefit;

8 (B) only for accidental death or dismemberment;

9 (C) for wages or payments in lieu of wages for a
10 period during which an employee is absent from work because of
11 sickness or injury;

12 (D) as a supplement to a liability insurance
13 policy;

14 (E) for credit insurance;

15 (F) only for dental or vision care; or

16 (G) only for indemnity for hospital confinement;

17 (2) a small employer health benefit plan written under
18 Chapter 1501;

19 (3) a Medicare supplemental policy as defined by
20 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

21 (4) a workers' compensation insurance policy;

22 (5) medical payment insurance coverage provided under
23 a motor vehicle insurance policy; or

24 (6) a long-term care insurance policy, including a
25 nursing home fixed indemnity policy, unless the commissioner
26 determines that the policy provides benefit coverage so
27 comprehensive that the policy is a health benefit plan as described

1 by Section 1367.051. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added
2 Acts 75th Leg., R.S., Ch. 683.)

3 Sec. 1367.053. COVERAGE REQUIRED. (a) A health benefit
4 plan that provides coverage for a family member of an insured or
5 enrollee shall provide for each covered child from birth through
6 the date of the child's sixth birthday coverage for:

7 (1) immunization against:

8 (A) diphtheria;

9 (B) haemophilus influenzae type b;

10 (C) hepatitis B;

11 (D) measles;

12 (E) mumps;

13 (F) pertussis;

14 (G) polio;

15 (H) rubella;

16 (I) tetanus; and

17 (J) varicella; and

18 (2) any other immunization that is required for the
19 child by law.

20 (b) For purposes of Subsection (a), a covered child is a
21 child who, as a result of the child's relationship to an insured or
22 enrollee in a health benefit plan, would be entitled to coverage
23 under an accident and health insurance policy under Section
24 1201.061, 1201.062, 1201.063, or 1201.064.

25 (c) In addition to the immunizations required under
26 Subsection (a), a health maintenance organization that issues a
27 health benefit plan shall provide under the plan coverage for

1 immunization against rotovirus. (V.T.I.C. Art. 20A.09F; Art.
2 21.53F, Secs. 3, 5, as added Acts 75th Leg., R.S., Ch. 683.)

3 Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE
4 REQUIREMENT PROHIBITED. (a) Coverage required under Section
5 1367.053(a) may not be made subject to a deductible, copayment, or
6 coinsurance requirement.

7 (b) This section does not prohibit the application of a
8 deductible, copayment, or coinsurance requirement to another
9 service provided at the same time the immunization is administered.
10 (V.T.I.C. Art. 21.53F, Sec. 6(a), as added Acts 75th Leg., R.S., Ch.
11 683.)

12 Sec. 1367.055. RULES. The commissioner may adopt
13 reasonable rules necessary to implement this subchapter. (V.T.I.C.
14 Art. 21.53F, Sec. 7, as added Acts 75th Leg., R.S., Ch. 683.)

15 [Sections 1367.056-1367.100 reserved for expansion]

16 SUBCHAPTER C. HEARING TEST

17 Sec. 1367.101. APPLICABILITY OF SUBCHAPTER. (a) This
18 subchapter applies only to a health benefit plan that:

19 (1) provides benefits for medical or surgical expenses
20 incurred as a result of a health condition, accident, or sickness,
21 including an individual, group, blanket, or franchise insurance
22 policy or insurance agreement, a group hospital service contract,
23 or an individual or group evidence of coverage that is offered by:

24 (A) an insurance company;

25 (B) a group hospital service corporation
26 operating under Chapter 842;

27 (C) a fraternal benefit society operating under

Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

(b) This subchapter applies to a health benefit plan described by Subsection (a) that provides coverage to a resident of this state, regardless of whether the plan issuer is located in or outside this state. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), 4(c) (part), as added Acts 75th Leg., R.S., Ch. 683.)

Sec. 1367.102. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of

1 sickness or injury;

2 (D) as a supplement to a liability insurance
3 policy;

4 (E) for credit insurance;

5 (F) only for dental or vision care; or

6 (G) only for indemnity for hospital confinement;

7 (2) a small employer health benefit plan written under
8 Chapter 1501;

9 (3) a Medicare supplemental policy as defined by
10 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

11 (4) a workers' compensation insurance policy;

12 (5) medical payment insurance coverage provided under
13 a motor vehicle insurance policy; or

14 (6) a long-term care insurance policy, including a
15 nursing home fixed indemnity policy, unless the commissioner
16 determines that the policy provides benefit coverage so
17 comprehensive that the policy is a health benefit plan as described
18 by Section 1367.101. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added
19 Acts 75th Leg., R.S., Ch. 683.)

20 Sec. 1367.103. COVERAGE REQUIRED. (a) A health benefit
21 plan that provides coverage for a family member of an insured or
22 enrollee shall provide to each covered child coverage for:

23 (1) a screening test for hearing loss from birth
24 through the date the child is 30 days of age, as provided by Chapter
25 47, Health and Safety Code; and

26 (2) necessary diagnostic follow-up care related to the
27 screening test from birth through the date the child is 24 months of

1 age.

2 (b) For purposes of Subsection (a), a covered child is a
3 child who, as a result of the child's relationship to an insured or
4 enrollee in a health benefit plan, would be entitled to coverage
5 under an accident and health insurance policy under Section
6 1201.061, 1201.062, 1201.063, or 1201.064.

7 (c) This section does not require a health benefit plan to
8 provide the coverage described by this section to a child of an
9 individual residing in this state if the individual is:

10 (1) employed outside this state; and

11 (2) covered under a health benefit plan maintained for
12 the individual by the individual's employer as an employment
13 benefit. (V.T.I.C. Art. 21.53F, Secs. 4(a), (c) (part), 5, as added
14 Acts 75th Leg., R.S., Ch. 683.)

15 Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT
16 PERMITTED; DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT PROHIBITED;
17 NOTICE REQUIRED. (a) Coverage required under this subchapter:

18 (1) may be subject to a copayment or coinsurance
19 requirement; and

20 (2) may not be subject to a deductible requirement or a
21 dollar limit.

22 (b) The requirements of this section must be stated in the
23 coverage document. (V.T.I.C. Art. 21.53F, Sec. 6(b), as added Acts
24 75th Leg., R.S., Ch. 683.)

25 Sec. 1367.105. RULES. The commissioner may adopt rules
26 necessary to implement this subchapter. (V.T.I.C. Art. 21.53F,
27 Secs. 4(b), 7, as added Acts 75th Leg., R.S., Ch. 683.)

[Sections 1367.106-1367.150 reserved for expansion]

SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

Sec. 1367.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly

1 for health care services on a risk-sharing basis, including a
2 capitation basis; or

3 (iii) another analogous benefit
4 arrangement; or

5 (2) is offered by an approved nonprofit health
6 corporation that holds a certificate of authority under Chapter
7 844. (V.T.I.C. Art. 21.53W, Sec. 2(a).)

8 Sec. 1367.152. EXCEPTION. This subchapter does not apply
9 to:

10 (1) a plan that provides coverage:

11 (A) only for a specified disease or for another
12 limited benefit;

13 (B) only for accidental death or dismemberment;

14 (C) for wages or payments in lieu of wages for a
15 period during which an employee is absent from work because of
16 sickness or injury;

17 (D) as a supplement to a liability insurance
18 policy;

19 (E) for credit insurance;

20 (F) only for dental or vision care; or

21 (G) only for indemnity for hospital confinement
22 or other hospital expenses;

23 (2) a small employer health benefit plan written under
24 Chapter 1501;

25 (3) a Medicare supplemental policy as defined by
26 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

27 (4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.151. (V.T.I.C. Art. 21.53W, Sec. 2(b).)

Sec. 1367.153. RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES; DEFINITION REQUIRED. A health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. (V.T.I.C. Art. 21.53W, Sec. 3.)

Sec. 1367.154. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 21.53W, Sec. 4.)

CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

Sec. 1368.001. DEFINITIONS

Sec. 1368.002. APPLICABILITY OF CHAPTER

Sec. 1368.003. EXCEPTION

Sec. 1368.004. COVERAGE REQUIRED

Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS

Sec. 1368.006. LIMITATION ON COVERAGE

Sec. 1368.007. TREATMENT STANDARDS

1 Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY

2 WITH CHAPTER

3 CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

4 Sec. 1368.001. DEFINITIONS. In this chapter:

5 (1) "Chemical dependency" means the abuse of, a
6 psychological or physical dependence on, or an addiction to alcohol
7 or a controlled substance.

8 (2) "Chemical dependency treatment center" means a
9 facility that provides a program for the treatment of chemical
10 dependency under a written treatment plan approved and monitored by
11 a physician and that is:

12 (A) affiliated with a hospital under a
13 contractual agreement with an established system for patient
14 referral;

15 (B) accredited as a chemical dependency
16 treatment center by the Joint Commission on Accreditation of
17 Healthcare Organizations;

18 (C) licensed as a chemical dependency treatment
19 program by the Texas Commission on Alcohol and Drug Abuse; or

20 (D) licensed, certified, or approved as a
21 chemical dependency treatment program or center by another state
22 agency.

23 (3) "Controlled substance" means an abusable volatile
24 chemical, as defined by Section 485.001, Health and Safety Code, or
25 a substance designated as a controlled substance under Chapter 481,
26 Health and Safety Code. (V.T.I.C. Art. 3.51-9, Secs. 2, 2A(e).)

27 Sec. 1368.002. APPLICABILITY OF CHAPTER. This chapter

1 applies only to a group health benefit plan that provides hospital
2 and medical coverage or services on an expense incurred, service,
3 or prepaid basis, including a group insurance policy or contract or
4 self-funded or self-insured plan or arrangement that is offered in
5 this state by:

- 6 (1) an insurer;
- 7 (2) a group hospital service corporation operating
8 under Chapter 842;
- 9 (3) a health maintenance organization operating under
10 Chapter 843; or
- 11 (4) an employer, trustee, or other self-funded or
12 self-insured plan or arrangement. (V.T.I.C. Art. 3.51-9, Sec.
13 2A(a) (part).)

14 Sec. 1368.003. EXCEPTION. This chapter does not apply to:

- 15 (1) an employer, trustee, or other self-funded or
16 self-insured plan or arrangement with 250 or fewer employees or
17 members;
- 18 (2) an individual insurance policy;
- 19 (3) an individual evidence of coverage issued by a
20 health maintenance organization;
- 21 (4) a health insurance policy that provides only:
 - 22 (A) cash indemnity for hospital or other
23 confinement benefits;
 - 24 (B) supplemental or limited benefit coverage;
 - 25 (C) coverage for specified diseases or
26 accidents;
 - 27 (D) disability income coverage; or

(E) any combination of those benefits or coverages;

(5) a blanket insurance policy;

(6) a short-term travel insurance policy;

(7) an accident-only insurance policy;

(8) a limited or specified disease insurance policy;

(9) an individual conversion insurance policy or contract;

(10) a policy or contract designed for issuance to a person eligible for Medicare coverage or other similar coverage under a state or federal government plan; or

(11) an evidence of coverage provided by a health maintenance organization if the plan holder is the subject of a collective bargaining agreement that was in effect on January 1, 1982, and that has not expired since that date. (V.T.I.C. Art. 3.51-9, Secs. 2A(c), 3 (part).)

Sec. 1368.004. COVERAGE REQUIRED. (a) A group health benefit plan shall provide coverage for the necessary care and treatment of chemical dependency.

(b) Coverage required under this section may be provided:

(1) directly by the group health benefit plan issuer;

or

(2) by another entity, including a single service health maintenance organization, under contract with the group health benefit plan issuer. (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS. (a) Except

1 as provided by Subsection (b), coverage required under this
2 chapter:

3 (1) may not be less favorable than coverage provided
4 for physical illness generally under the plan; and

5 (2) shall be subject to the same durational limits,
6 dollar limits, deductibles, and coinsurance factors that apply to
7 coverage provided for physical illness generally under the plan.

8 (b) A group health benefit plan may set dollar or durational
9 limits for coverage required under this chapter that are less
10 favorable than for coverage provided for physical illness generally
11 under the plan if those limits are sufficient to provide
12 appropriate care and treatment under the guidelines and standards
13 adopted under Section 1368.007. If guidelines and standards
14 adopted under Section 1368.007 are not in effect, the dollar and
15 durational limits may not be less favorable than for physical
16 illness generally.

17 (c) This section does not require payment of a usual,
18 customary, and reasonable rate for treatment of a covered
19 individual if a health maintenance organization or preferred
20 provider organization establishes a negotiated rate for the
21 locality in which the covered individual customarily receives care.
22 (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

23 Sec. 1368.006. LIMITATION ON COVERAGE. (a) In this
24 section, "treatment series" means a planned, structured, and
25 organized program to promote chemical-free status that:

26 (1) may include different facilities or modalities;
27 and

1 (2) is completed when the covered individual:

2 (A) is, on medical advice, discharged from:

3 (i) inpatient detoxification;

4 (ii) inpatient rehabilitation or
5 treatment;

6 (iii) partial hospitalization or intensive
7 outpatient treatment; or

8 (iv) a series of those levels of treatments
9 without a lapse in treatment; or

10 (B) fails to materially comply with the treatment
11 program for a period of 30 days.

12 (b) Notwithstanding Section 1368.005, coverage required
13 under this chapter is limited to a lifetime maximum of three
14 separate treatment series for each covered individual. (V.T.I.C.
15 Art. 3.51-9, Sec. 2A(b).)

16 Sec. 1368.007. TREATMENT STANDARDS. (a) Coverage provided
17 under this chapter for necessary care and treatment in a chemical
18 dependency treatment center must be provided as if the care and
19 treatment were provided in a hospital.

20 (b) The department by rule shall adopt standards formulated
21 and approved by the department and the Texas Commission on Alcohol
22 and Drug Abuse for use by insurers, other third-party reimbursement
23 sources, and chemical dependency treatment centers.

24 (c) Standards adopted under this section must provide for:

25 (1) reasonable control of costs necessary for
26 inpatient and outpatient treatment of chemical dependency,
27 including guidelines for treatment periods; and

(2) appropriate utilization review of treatment as well as necessary extensions of treatment.

(d) Coverage required under this chapter is subject to the standards adopted under this section. (V.T.I.C. Art. 3.51-9, Sec. 2A(d).)

Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY WITH CHAPTER. A group health benefit plan issuer that uses a policy form approved by the commissioner before November 10, 1981, may use an endorsement or rider to comply with this chapter if the endorsement or rider is approved by the commissioner as complying with this chapter and other provisions of this code. (V.T.I.C. Art. 3.51-9, Sec. 3 (part).)

CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS
AND DEVICES AND RELATED SERVICES

SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

Sec. 1369.001. DEFINITIONS

Sec. 1369.002. APPLICABILITY OF SUBCHAPTER

Sec. 1369.003. EXCEPTION

Sec. 1369.004. COVERAGE REQUIRED

Sec. 1369.005. RULES

[Sections 1369.006-1369.050 reserved for expansion]

SUBCHAPTER B. COVERAGE OF PRESCRIPTION DRUGS SPECIFIED
BY DRUG FORMULARY

Sec. 1369.051. DEFINITIONS

Sec. 1369.052. APPLICABILITY OF SUBCHAPTER

Sec. 1369.053. EXCEPTION

Sec. 1369.054. NOTICE AND DISCLOSURE OF CERTAIN INFORMATION

REQUIRED

Sec. 1369.055. CONTINUATION OF COVERAGE REQUIRED; OTHER

DRUGS NOT PRECLUDED

Sec. 1369.056. ADVERSE DETERMINATION

Sec. 1369.057. RULES

[Sections 1369.058-1369.100 reserved for expansion]

SUBCHAPTER C. COVERAGE OF PRESCRIPTION CONTRACEPTIVE

DRUGS AND DEVICES AND RELATED SERVICES

Sec. 1369.101. DEFINITIONS

Sec. 1369.102. APPLICABILITY OF SUBCHAPTER

Sec. 1369.103. EXCEPTION

Sec. 1369.104. EXCLUSION OR LIMITATION PROHIBITED

Sec. 1369.105. CERTAIN COST-SHARING PROVISIONS PROHIBITED

Sec. 1369.106. CERTAIN WAITING PERIODS PROHIBITED

Sec. 1369.107. PROHIBITED CONDUCT

Sec. 1369.108. EXEMPTION FOR ENTITIES ASSOCIATED WITH

RELIGIOUS ORGANIZATION

Sec. 1369.109. ENFORCEMENT

[Sections 1369.110-1369.150 reserved for expansion]

SUBCHAPTER D. PHARMACY BENEFIT CARDS

Sec. 1369.151. APPLICABILITY OF SUBCHAPTER

Sec. 1369.152. EXCEPTION

Sec. 1369.153. INFORMATION REQUIRED ON IDENTIFICATION CARD

Sec. 1369.154. RULES

CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS

AND DEVICES AND RELATED SERVICES

SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

1 Sec. 1369.001. DEFINITIONS. In this subchapter:

2 (1) "Contraindication" means the potential for, or the
3 occurrence of:

4 (A) an undesirable change in the therapeutic
5 effect of a prescribed drug because of the presence of a disease
6 condition in the patient for whom the drug is prescribed; or

7 (B) a clinically significant adverse effect of a
8 prescribed drug on a disease condition of the patient for whom the
9 drug is prescribed.

10 (2) "Drug" has the meaning assigned by Section
11 551.003, Occupations Code.

12 (3) "Indication" means a symptom, cause, or occurrence
13 in a disease that points out the cause, diagnosis, course of
14 treatment, or prognosis of the disease.

15 (4) "Peer-reviewed medical literature" means
16 scientific studies published in a peer-reviewed national
17 professional journal. (V.T.I.C. Art. 21.53M, Secs. 1(1), (2), (4),
18 (5).)

19 Sec. 1369.002. APPLICABILITY OF SUBCHAPTER. This
20 subchapter applies only to a health benefit plan that provides
21 benefits for medical or surgical expenses incurred as a result of a
22 health condition, accident, or sickness, including an individual,
23 group, blanket, or franchise insurance policy or insurance
24 agreement, a group hospital service contract, or an individual or
25 group evidence of coverage or similar coverage document that is
26 offered by:

27 (1) an insurance company;

1 (2) a group hospital service corporation operating
2 under Chapter 842;

3 (3) a fraternal benefit society operating under
4 Chapter 885;

5 (4) a stipulated premium company operating under
6 Chapter 884;

7 (5) a reciprocal exchange operating under Chapter 942;

8 (6) a health maintenance organization operating under
9 Chapter 843;

10 (7) a multiple employer welfare arrangement that holds
11 a certificate of authority under Chapter 846; or

12 (8) an approved nonprofit health corporation that
13 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
14 21.53M, Sec. 2(a).)

15 Sec. 1369.003. EXCEPTION. This subchapter does not apply
16 to:

17 (1) a health benefit plan that provides coverage:

18 (A) only for a specified disease or for another
19 limited benefit;

20 (B) only for accidental death or dismemberment;

21 (C) for wages or payments in lieu of wages for a
22 period during which an employee is absent from work because of
23 sickness or injury;

24 (D) as a supplement to a liability insurance
25 policy;

26 (E) for credit insurance;

27 (F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.002. (V.T.I.C. Art. 21.53M, Sec. 2(b).)

Sec. 1369.004. COVERAGE REQUIRED. (a) A health benefit plan that covers drugs must cover any drug prescribed to treat an enrollee for a chronic, disabling, or life-threatening illness covered under the plan if the drug:

(1) has been approved by the United States Food and Drug Administration for at least one indication; and

(2) is recognized by the following for treatment of the indication for which the drug is prescribed:

(A) a prescription drug reference compendium approved by the commissioner for purposes of this section; or

(B) substantially accepted peer-reviewed medical literature.

1 (b) Coverage of a drug required under Subsection (a) must
2 include coverage of medically necessary services associated with
3 the administration of the drug.

4 (c) A health benefit plan issuer may not, based on a
5 "medical necessity" requirement, deny coverage of a drug required
6 under Subsection (a) unless the reason for the denial is unrelated
7 to the legal status of the drug use.

8 (d) This section does not require a health benefit plan to
9 cover:

10 (1) experimental drugs that are not otherwise approved
11 for an indication by the United States Food and Drug
12 Administration;

13 (2) any disease or condition that is excluded from
14 coverage under the plan; or

15 (3) a drug that the United States Food and Drug
16 Administration has determined to be contraindicated for treatment
17 of the current indication. (V.T.I.C. Art. 21.53M, Sec. 3.)

18 Sec. 1369.005. RULES. The commissioner may adopt rules to
19 implement this subchapter. (V.T.I.C. Art. 21.53M, Sec. 4.)

20 [Sections 1369.006-1369.050 reserved for expansion]

21 SUBCHAPTER B. COVERAGE OF PRESCRIPTION DRUGS SPECIFIED BY

22 DRUG FORMULARY

23 Sec. 1369.051. DEFINITIONS. In this subchapter:

24 (1) "Drug formulary" means a list of drugs:

25 (A) for which a health benefit plan provides
26 coverage;

27 (B) for which a health benefit plan issuer

1 approves payment; or

2 (C) that a health benefit plan issuer encourages
3 or offers incentives for physicians to prescribe.

4 (2) "Enrollee" means an individual who is covered
5 under a group health benefit plan, including a covered dependent.

6 (3) "Physician" means a person licensed as a physician
7 by the Texas State Board of Medical Examiners.

8 (4) "Prescription drug" has the meaning assigned by
9 Section 551.003, Occupations Code. (V.T.I.C. Art. 21.52J, Secs.
10 1(1), (2), (4), (5).)

11 Sec. 1369.052. APPLICABILITY OF SUBCHAPTER. This
12 subchapter applies only to a group health benefit plan that
13 provides benefits for medical or surgical expenses incurred as a
14 result of a health condition, accident, or sickness, including a
15 group, blanket, or franchise insurance policy or insurance
16 agreement, a group hospital service contract, or a group contract
17 or similar coverage document that is offered by:

18 (1) an insurance company;

19 (2) a group hospital service corporation operating
20 under Chapter 842;

21 (3) a fraternal benefit society operating under
22 Chapter 885;

23 (4) a stipulated premium company operating under
24 Chapter 884;

25 (5) a reciprocal exchange operating under Chapter 942;

26 (6) a health maintenance organization operating under
27 Chapter 843;

1 (7) a multiple employer welfare arrangement that holds
2 a certificate of authority under Chapter 846; or

3 (8) an approved nonprofit health corporation that
4 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
5 21.52J, Sec. 2(a).)

6 Sec. 1369.053. EXCEPTION. This subchapter does not apply
7 to:

8 (1) a health benefit plan that provides coverage:

9 (A) only for a specified disease or for another
10 single benefit;

11 (B) only for accidental death or dismemberment;

12 (C) for wages or payments in lieu of wages for a
13 period during which an employee is absent from work because of
14 sickness or injury;

15 (D) as a supplement to a liability insurance
16 policy;

17 (E) for credit insurance;

18 (F) only for dental or vision care;

19 (G) only for hospital expenses; or

20 (H) only for indemnity for hospital confinement;

21 (2) a small employer health benefit plan written under
22 Chapter 1501;

23 (3) a Medicare supplemental policy as defined by
24 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
25 as amended;

26 (4) a workers' compensation insurance policy;

27 (5) medical payment insurance coverage provided under

1 a motor vehicle insurance policy; or

2 (6) a long-term care insurance policy, including a
3 nursing home fixed indemnity policy, unless the commissioner
4 determines that the policy provides benefit coverage so
5 comprehensive that the policy is a health benefit plan as described
6 by Section 1369.052. (V.T.I.C. Art. 21.52J, Sec. 2(b).)

7 Sec. 1369.054. NOTICE AND DISCLOSURE OF CERTAIN INFORMATION
8 REQUIRED. An issuer of a group health benefit plan that covers
9 prescription drugs and uses one or more drug formularies to specify
10 the prescription drugs covered under the plan shall:

11 (1) provide in plain language in the coverage
12 documentation provided to each enrollee:

13 (A) notice that the plan uses one or more drug
14 formularies;

15 (B) an explanation of what a drug formulary is;

16 (C) a statement regarding the method the issuer
17 uses to determine the prescription drugs to be included in or
18 excluded from a drug formulary;

19 (D) a statement of how often the issuer reviews
20 the contents of each drug formulary; and

21 (E) notice that an enrollee may contact the
22 issuer to determine whether a specific drug is included in a
23 particular drug formulary;

24 (2) disclose to an individual on request, not later
25 than the third business day after the date of the request, whether a
26 specific drug is included in a particular drug formulary; and

27 (3) notify an enrollee and any other individual who

1 requests information under this section that the inclusion of a
2 drug in a drug formulary does not guarantee that an enrollee's
3 health care provider will prescribe that drug for a particular
4 medical condition or mental illness. (V.T.I.C. Art. 21.52J, Sec.
5 3.)

6 Sec. 1369.055. CONTINUATION OF COVERAGE REQUIRED; OTHER
7 DRUGS NOT PRECLUDED. (a) An issuer of a group health benefit plan
8 that covers prescription drugs shall offer to each enrollee at the
9 contracted benefit level and until the enrollee's plan renewal date
10 any prescription drug that was approved or covered under the plan
11 for a medical condition or mental illness, regardless of whether
12 the drug has been removed from the health benefit plan's drug
13 formulary before the plan renewal date.

14 (b) This section does not prohibit a physician or other
15 health professional who is authorized to prescribe a drug from
16 prescribing a drug that is an alternative to a drug for which
17 continuation of coverage is required under Subsection (a) if the
18 alternative drug is:

- 19 (1) covered under the group health benefit plan; and
20 (2) medically appropriate for the enrollee. (V.T.I.C.
21 Art. 21.52J, Sec. 4.)

22 Sec. 1369.056. ADVERSE DETERMINATION. (a) The refusal of a
23 group health benefit plan issuer to provide benefits to an enrollee
24 for a prescription drug is an adverse determination for purposes of
25 Section 2, Article 21.58A, if:

- 26 (1) the drug is not included in a drug formulary used
27 by the group health benefit plan; and

1 (2) the enrollee's physician has determined that the
2 drug is medically necessary.

3 (b) The enrollee may appeal the adverse determination under
4 Sections 6 and 6A, Article 21.58A. (V.T.I.C. Art. 21.52J, Sec. 5.)

5 Sec. 1369.057. RULES. The commissioner may adopt rules to
6 implement this subchapter. (V.T.I.C. Art. 21.52J, Sec. 6.)

7 [Sections 1369.058-1369.100 reserved for expansion]

8 SUBCHAPTER C. COVERAGE OF PRESCRIPTION CONTRACEPTIVE

9 DRUGS AND DEVICES AND RELATED SERVICES

10 Sec. 1369.101. DEFINITIONS. In this subchapter:

11 (1) "Enrollee" means a person who is entitled to
12 benefits under a health benefit plan.

13 (2) "Outpatient contraceptive service" means a
14 consultation, examination, procedure, or medical service that is
15 provided on an outpatient basis and that is related to the use of a
16 drug or device intended to prevent pregnancy. (V.T.I.C. Art.
17 21.52L, Sec. 1, as added Acts 77th Leg., R.S., Ch. 1106.)

18 Sec. 1369.102. APPLICABILITY OF SUBCHAPTER. This
19 subchapter applies only to a health benefit plan, including a small
20 employer health benefit plan written under Chapter 1501, that
21 provides benefits for medical or surgical expenses incurred as a
22 result of a health condition, accident, or sickness, including an
23 individual, group, blanket, or franchise insurance policy or
24 insurance agreement, a group hospital service contract, or an
25 individual or group evidence of coverage or similar coverage
26 document that is offered by:

27 (1) an insurance company;

1 (2) a group hospital service corporation operating
2 under Chapter 842;

3 (3) a fraternal benefit society operating under
4 Chapter 885;

5 (4) a stipulated premium company operating under
6 Chapter 884;

7 (5) a reciprocal exchange operating under Chapter 942;

8 (6) a health maintenance organization operating under
9 Chapter 843;

10 (7) a multiple employer welfare arrangement that holds
11 a certificate of authority under Chapter 846; or

12 (8) an approved nonprofit health corporation that
13 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
14 21.52L, Secs. 2(a), (b), as added Acts 77th Leg., R.S., Ch. 1106.)

15 Sec. 1369.103. EXCEPTION. This subchapter does not apply
16 to:

17 (1) a health benefit plan that provides coverage only:

18 (A) for a specified disease or for another
19 limited benefit other than for cancer;

20 (B) for accidental death or dismemberment;

21 (C) for wages or payments in lieu of wages for a
22 period during which an employee is absent from work because of
23 sickness or injury;

24 (D) as a supplement to a liability insurance
25 policy;

26 (E) for credit insurance;

27 (F) for dental or vision care; or

(G) for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.102. (V.T.I.C. Art. 21.52L, Sec. 2(c), as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.104. EXCLUSION OR LIMITATION PROHIBITED. (a) A health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for:

(1) a prescription contraceptive drug or device approved by the United States Food and Drug Administration; or

(2) an outpatient contraceptive service.

(b) This section does not prohibit a limitation that applies to all prescription drugs or devices or all services for which benefits are provided under a health benefit plan.

(c) This section does not require a health benefit plan to cover abortifacients or any other drug or device that terminates a pregnancy. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th Leg., R.S., Ch. 1106.)

Sec. 1369.105. CERTAIN COST-SHARING PROVISIONS PROHIBITED.

1 (a) A health benefit plan may not impose a deductible, copayment,
2 coinsurance, or other cost-sharing provision applicable to
3 benefits for prescription contraceptive drugs or devices unless the
4 amount of the required cost-sharing is the same as or less than the
5 amount of the required cost-sharing applicable to benefits for
6 other prescription drugs or devices under the plan.

7 (b) A health benefit plan may not impose a deductible,
8 copayment, coinsurance, or other cost-sharing provision applicable
9 to benefits for outpatient contraceptive services unless the amount
10 of the required cost-sharing is the same as or less than the amount
11 of the required cost-sharing applicable to benefits for other
12 outpatient services under the plan. (V.T.I.C. Art. 21.52L, Sec. 4,
13 as added Acts 77th Leg., R.S., Ch. 1106.)

14 Sec. 1369.106. CERTAIN WAITING PERIODS PROHIBITED. (a) A
15 health benefit plan may not impose a waiting period applicable to
16 benefits for prescription contraceptive drugs or devices unless the
17 waiting period is the same as or shorter than any waiting period
18 applicable to benefits for other prescription drugs or devices
19 under the plan.

20 (b) A health benefit plan may not impose a waiting period
21 applicable to benefits for outpatient contraceptive services
22 unless the waiting period is the same as or shorter than any waiting
23 period applicable to benefits for other outpatient services under
24 the plan. (V.T.I.C. Art. 21.52L, Sec. 5, as added Acts 77th Leg.,
25 R.S., Ch. 1106.)

26 Sec. 1369.107. PROHIBITED CONDUCT. A health benefit plan
27 issuer may not:

1 (1) solely because of the applicant's or enrollee's
2 use or potential use of a prescription contraceptive drug or device
3 or an outpatient contraceptive service, deny:

4 (A) the eligibility of an applicant to enroll in
5 the plan;

6 (B) the continued eligibility of an enrollee for
7 coverage under the plan; or

8 (C) the eligibility of an enrollee to renew
9 coverage under the plan;

10 (2) provide a monetary incentive to an applicant for
11 enrollment or an enrollee to induce the applicant or enrollee to
12 accept coverage that does not satisfy the requirements of this
13 subchapter; or

14 (3) reduce or limit a payment to a health care
15 professional, or otherwise penalize the professional, because the
16 professional prescribes a contraceptive drug or device or provides
17 an outpatient contraceptive service. (V.T.I.C. Art. 21.52L, Sec.
18 6, as added Acts 77th Leg., R.S., Ch. 1106.)

19 Sec. 1369.108. EXEMPTION FOR ENTITIES ASSOCIATED WITH
20 RELIGIOUS ORGANIZATION. (a) This subchapter does not require a
21 health benefit plan that is issued by an entity associated with a
22 religious organization or any physician or health care provider
23 providing medical or health care services under the plan to offer,
24 recommend, offer advice concerning, pay for, provide, assist in,
25 perform, arrange, or participate in providing or performing a
26 medical or health care service that violates the religious
27 convictions of the organization, unless the prescription

1 contraceptive coverage is necessary to preserve the life or health
2 of the enrollee.

3 (b) An issuer of a health benefit plan that excludes or
4 limits coverage for medical or health care services under this
5 section shall state the exclusion or limitation in:

6 (1) the plan's coverage document;

7 (2) the plan's statement of benefits;

8 (3) plan brochures; and

9 (4) other informational materials for the plan.

10 (V.T.I.C. Art. 21.52L, Sec. 7, as added Acts 77th Leg., R.S., Ch.
11 1106.)

12 Sec. 1369.109. ENFORCEMENT. A health benefit plan issuer
13 that violates this subchapter is subject to the enforcement
14 provisions of Subtitle B, Title 2. (V.T.I.C. Art. 21.52L, Sec. 8,
15 as added Acts 77th Leg., R.S., Ch. 1106.)

16 [Sections 1369.110-1369.150 reserved for expansion]

17 SUBCHAPTER D. PHARMACY BENEFIT CARDS

18 Sec. 1369.151. APPLICABILITY OF SUBCHAPTER. This
19 subchapter applies only to a health benefit plan that provides
20 benefits for medical or surgical expenses incurred as a result of a
21 health condition, accident, or sickness, including an individual,
22 group, blanket, or franchise insurance policy or insurance
23 agreement, a group hospital service contract, or an individual or
24 group evidence of coverage or similar coverage document that is
25 offered by:

26 (1) an insurance company;

27 (2) a group hospital service corporation operating

1 under Chapter 842;

2 (3) a fraternal benefit society operating under
3 Chapter 885;

4 (4) a stipulated premium company operating under
5 Chapter 884;

6 (5) a reciprocal exchange operating under Chapter 942;

7 (6) a health maintenance organization operating under
8 Chapter 843;

9 (7) a multiple employer welfare arrangement that holds
10 a certificate of authority under Chapter 846; or

11 (8) an approved nonprofit health corporation that
12 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
13 21.53L, Sec. 2(a).)

14 Sec. 1369.152. EXCEPTION. This subchapter does not apply
15 to:

16 (1) a health benefit plan that provides coverage:

17 (A) only for a specified disease or for another
18 limited benefit;

19 (B) only for accidental death or dismemberment;

20 (C) for wages or payments in lieu of wages for a
21 period during which an employee is absent from work because of
22 sickness or injury;

23 (D) as a supplement to a liability insurance
24 policy;

25 (E) for credit insurance;

26 (F) only for dental or vision care;

27 (G) only for hospital expenses; or

1 (H) only for indemnity for hospital confinement;
2 (2) a small employer health benefit plan written under
3 Chapter 1501;

4 (3) a Medicare supplemental policy as defined by
5 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

6 (4) a workers' compensation insurance policy;

7 (5) medical payment insurance coverage provided under
8 a motor vehicle insurance policy; or

9 (6) a long-term care insurance policy, including a
10 nursing home fixed indemnity policy, unless the commissioner
11 determines that the policy provides benefit coverage so
12 comprehensive that the policy is a health benefit plan as described
13 by Section 1369.151. (V.T.I.C. Art. 21.53L, Sec. 2(b).)

14 Sec. 1369.153. INFORMATION REQUIRED ON IDENTIFICATION
15 CARD. (a) An issuer of a health benefit plan that provides
16 pharmacy benefits to enrollees shall include on the identification
17 card of each enrollee:

18 (1) the name or logo of the entity administering the
19 pharmacy benefits if the entity is different from the health
20 benefit plan issuer;

21 (2) the group number applicable to the enrollee;

22 (3) the effective date of the coverage evidenced by
23 the card;

24 (4) a telephone number for contacting an appropriate
25 person to obtain information relating to the pharmacy benefits
26 provided under the plan; and

27 (5) copayment information for generic and brand-name

1 prescription drugs.

2 (b) This section does not require a health benefit plan
3 issuer that administers its own pharmacy benefits to issue an
4 identification card separate from any identification card issued to
5 an enrollee to evidence coverage under the plan if the
6 identification card issued to evidence coverage contains the
7 information required by Subsection (a). (V.T.I.C. Art. 21.53L,
8 Sec. 3.)

9 Sec. 1369.154. RULES. The commissioner shall adopt rules as
10 necessary to implement this subchapter. (V.T.I.C. Art. 21.53L,
11 Sec. 4.)

12 [Chapters 1370-1450 reserved for expansion]

13 SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

14 CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND FACILITIES

15 SUBCHAPTER A. GENERAL PROVISIONS

16 Sec. 1451.001. DEFINITIONS; HEALTH CARE PRACTITIONERS

17 [Sections 1451.002-1451.050 reserved for expansion]

18 SUBCHAPTER B. DESIGNATION OF PRACTITIONERS UNDER ACCIDENT

19 AND HEALTH INSURANCE POLICY

20 Sec. 1451.051. APPLICABILITY OF SUBCHAPTER

21 Sec. 1451.052. APPLICABILITY OF GENERAL PROVISIONS OF

22 OTHER LAW

23 Sec. 1451.053. PRACTITIONER DESIGNATION

24 Sec. 1451.054. TERMS USED TO DESIGNATE HEALTH CARE

25 PRACTITIONERS

26 [Sections 1451.055-1451.100 reserved for expansion]

27 SUBCHAPTER C. SELECTION OF PRACTITIONERS

- 1 Sec. 1451.101. DEFINITIONS
- 2 Sec. 1451.102. APPLICABILITY OF SUBCHAPTER
- 3 Sec. 1451.103. CONFLICTING PROVISIONS VOID
- 4 Sec. 1451.104. NONDISCRIMINATORY PAYMENT OR REIMBURSEMENT;
- 5 EXCEPTION
- 6 Sec. 1451.105. SELECTION OF ACUPUNCTURIST
- 7 Sec. 1451.106. SELECTION OF ADVANCED PRACTICE NURSE
- 8 Sec. 1451.107. SELECTION OF AUDIOLOGIST
- 9 Sec. 1451.108. SELECTION OF CHEMICAL DEPENDENCY COUNSELOR
- 10 Sec. 1451.109. SELECTION OF CHIROPRACTOR
- 11 Sec. 1451.110. SELECTION OF DENTIST
- 12 Sec. 1451.111. SELECTION OF DIETITIAN
- 13 Sec. 1451.112. SELECTION OF HEARING INSTRUMENT FITTER
- 14 AND DISPENSER
- 15 Sec. 1451.113. SELECTION OF LICENSED MASTER SOCIAL
- 16 WORKER--ADVANCED CLINICAL PRACTITIONER
- 17 Sec. 1451.114. SELECTION OF LICENSED PROFESSIONAL
- 18 COUNSELOR
- 19 Sec. 1451.115. SELECTION OF SURGICAL ASSISTANT
- 20 Sec. 1451.116. SELECTION OF MARRIAGE AND FAMILY THERAPIST
- 21 Sec. 1451.117. SELECTION OF NURSE FIRST ASSISTANT
- 22 Sec. 1451.118. SELECTION OF OCCUPATIONAL THERAPIST
- 23 Sec. 1451.119. SELECTION OF OPTOMETRIST
- 24 Sec. 1451.120. SELECTION OF PHYSICAL THERAPIST
- 25 Sec. 1451.121. SELECTION OF PHYSICIAN ASSISTANT
- 26 Sec. 1451.122. SELECTION OF PODIATRIST
- 27 Sec. 1451.123. SELECTION OF PSYCHOLOGICAL ASSOCIATE

1 Sec. 1451.124. SELECTION OF PSYCHOLOGIST

2 Sec. 1451.125. SELECTION OF SPEECH-LANGUAGE PATHOLOGIST

3 Sec. 1451.126. REIMBURSEMENT FOR PHYSICAL MODALITIES AND
4 PROCEDURES BY HEALTH INSURER, ADMINISTRATOR,
5 HEALTH MAINTENANCE ORGANIZATION, OR
6 PREFERRED PROVIDER BENEFIT PLAN ISSUER

7 Sec. 1451.127. DUTY OF PERSON ARRANGING PROVIDER
8 CONTRACTS FOR HEALTH INSURER OR HEALTH
9 MAINTENANCE ORGANIZATION

10 [Sections 1451.128-1451.150 reserved for expansion]

11 SUBCHAPTER D. ACCESS TO OPTOMETRISTS AND OPHTHALMOLOGISTS
12 USED UNDER MANAGED CARE PLAN

13 Sec. 1451.151. DEFINITIONS

14 Sec. 1451.152. APPLICABILITY AND CONSTRUCTION OF
15 SUBCHAPTER

16 Sec. 1451.153. USE OF OPTOMETRIST, THERAPEUTIC
17 OPTOMETRIST, OR OPHTHALMOLOGIST

18 [Sections 1451.154-1451.200 reserved for expansion]

19 SUBCHAPTER E. DENTAL CARE BENEFITS IN HEALTH INSURANCE
20 POLICIES OR EMPLOYEE BENEFIT PLANS

21 Sec. 1451.201. DEFINITIONS

22 Sec. 1451.202. APPLICABILITY AND CONSTRUCTION OF
23 SUBCHAPTER

24 Sec. 1451.203. CONFLICTING PROVISIONS

25 Sec. 1451.204. CERTAIN CONDUCT PERMITTED

26 Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS

27 Sec. 1451.206. PAYMENT OR REIMBURSEMENT OF DENTIST

1 Sec. 1451.207. PROHIBITED CONDUCT

2 [Sections 1451.208-1451.250 reserved for expansion]

3 SUBCHAPTER F. ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE

4 Sec. 1451.251. DEFINITION

5 Sec. 1451.252. APPLICABILITY OF SUBCHAPTER

6 Sec. 1451.253. EXCEPTION

7 Sec. 1451.254. RULES

8 Sec. 1451.255. RIGHT OF FEMALE ENROLLEE TO SELECT

9 OBSTETRICIAN OR GYNECOLOGIST

10 Sec. 1451.256. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN

11 OR GYNECOLOGIST

12 Sec. 1451.257. AVAILABILITY OF PROVIDERS

13 Sec. 1451.258. NOTICE OF AVAILABLE PROVIDERS

14 Sec. 1451.259. LIMITS ON PHYSICIAN SANCTIONS

15 Sec. 1451.260. ADMINISTRATIVE PENALTY

16 [Sections 1451.261-1451.300 reserved for expansion]

17 SUBCHAPTER G. ACCESS TO DIETITIAN SERVICES

18 Sec. 1451.301. APPLICABILITY OF GENERAL PROVISIONS OF

19 OTHER LAW

20 Sec. 1451.302. DIETITIAN SERVICES

21 [Sections 1451.303-1451.350 reserved for expansion]

22 SUBCHAPTER H. DISABILITY CERTIFIED BY PODIATRIST

23 Sec. 1451.351. LOSS OF INCOME BENEFITS FOR DISABILITY

24 TREATABLE BY PODIATRIST

25 [Sections 1451.352-1451.400 reserved for expansion]

26 SUBCHAPTER I. USE OF OSTEOPATHIC HOSPITAL

27 Sec. 1451.401. CONTRACT WITH OSTEOPATHIC HOSPITAL

1 Sec. 1451.402. SERVICES AT OSTEOPATHIC HOSPITAL

2 Sec. 1451.403. REQUEST FOR ACTION OF COMMISSIONER

3 Sec. 1451.404. ENFORCEMENT

4 CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND FACILITIES

5 SUBCHAPTER A. GENERAL PROVISIONS

6 Sec. 1451.001. DEFINITIONS; HEALTH CARE PRACTITIONERS. In
7 this chapter:

8 (1) "Acupuncturist" means an individual licensed to
9 practice acupuncture by the Texas State Board of Medical Examiners.

10 (2) "Advanced practice nurse" means an individual
11 licensed by the Board of Nurse Examiners as a registered nurse and
12 recognized by that board as an advanced practice nurse.

13 (3) "Audiologist" means an individual licensed to
14 practice audiology by the State Board of Examiners for
15 Speech-Language Pathology and Audiology.

16 (4) "Chemical dependency counselor" means an
17 individual licensed by the Texas Commission on Alcohol and Drug
18 Abuse.

19 (5) "Chiropractor" means an individual licensed by the
20 Texas Board of Chiropractic Examiners.

21 (6) "Dentist" means an individual licensed to practice
22 dentistry by the State Board of Dental Examiners.

23 (7) "Dietitian" means an individual licensed by the
24 Texas State Board of Examiners of Dietitians.

25 (8) "Hearing instrument fitter and dispenser" means an
26 individual licensed by the State Committee of Examiners in the
27 Fitting and Dispensing of Hearing Instruments.

1 (9) "Licensed master social worker--advanced clinical
2 practitioner" means an individual licensed by the Texas State Board
3 of Social Worker Examiners as a licensed master social worker with
4 the order of recognition of advanced clinical practitioner.

5 (10) "Licensed professional counselor" means an
6 individual licensed by the Texas State Board of Examiners of
7 Professional Counselors.

8 (11) "Marriage and family therapist" means an
9 individual licensed by the Texas State Board of Examiners of
10 Marriage and Family Therapists.

11 (12) "Occupational therapist" means an individual
12 licensed as an occupational therapist by the Texas Board of
13 Occupational Therapy Examiners.

14 (13) "Optometrist" means an individual licensed to
15 practice optometry by the Texas Optometry Board.

16 (14) "Physical therapist" means an individual
17 licensed as a physical therapist by the Texas Board of Physical
18 Therapy Examiners.

19 (15) "Physician" means an individual licensed to
20 practice medicine by the Texas State Board of Medical Examiners.
21 The term includes a doctor of osteopathic medicine.

22 (16) "Physician assistant" means an individual
23 licensed by the Texas State Board of Physician Assistant Examiners.

24 (17) "Podiatrist" means an individual licensed to
25 practice podiatry by the Texas State Board of Podiatric Medical
26 Examiners.

27 (18) "Psychological associate" means an individual

1 licensed as a psychological associate by the Texas State Board of
2 Examiners of Psychologists who practices solely under the
3 supervision of a licensed psychologist.

4 (19) "Psychologist" means an individual licensed as a
5 psychologist by the Texas State Board of Examiners of
6 Psychologists.

7 (20) "Speech-language pathologist" means an
8 individual licensed to practice speech-language pathology by the
9 State Board of Examiners for Speech-Language Pathology and
10 Audiology.

11 (21) "Surgical assistant" means an individual
12 licensed as a surgical assistant by the Texas State Board of Medical
13 Examiners. (V.T.I.C. Art. 3.70-2, Sec. (B) (part); Art. 21.52,
14 Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

15 [Sections 1451.002-1451.050 reserved for expansion]

16 SUBCHAPTER B. DESIGNATION OF PRACTITIONERS UNDER ACCIDENT
17 AND HEALTH INSURANCE POLICY

18 Sec. 1451.051. APPLICABILITY OF SUBCHAPTER. (a) This
19 subchapter applies to an accident and health insurance policy,
20 including an individual, blanket, or group policy.

21 (b) This subchapter applies to an accident and health
22 insurance policy issued by a stipulated premium company subject to
23 Chapter 884. (V.T.I.C. Art. 3.70-8, Secs. (a) (part), (b).)

24 Sec. 1451.052. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
25 LAW. The provisions of Chapter 1201, including provisions relating
26 to the applicability, purpose, and enforcement of that chapter, the
27 construction of policies under that chapter, rulemaking under that

chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Sec. 1451.053. PRACTITIONER DESIGNATION. (a) An accident and health insurance policy may not make a benefit contingent on treatment or examination by one or more particular health care practitioners listed in Section 1451.001 unless the policy contains a provision that designates the practitioners whom the insurer will and will not recognize.

(b) The insurer may include the provision anywhere in the policy or in an endorsement attached to the policy. (V.T.I.C. Art. 3.70-2, Sec. (B) (part).)

Sec. 1451.054. TERMS USED TO DESIGNATE HEALTH CARE PRACTITIONERS. A provision of an accident and health insurance policy that designates the health care practitioners whom the insurer will and will not recognize must use the terms defined by Section 1451.001 with the meanings assigned by that section. (V.T.I.C. Art. 3.70-2, Sec. (B) (part).)

[Sections 1451.055-1451.100 reserved for expansion]

SUBCHAPTER C. SELECTION OF PRACTITIONERS

Sec. 1451.101. DEFINITIONS. In this subchapter:

(1) "Health insurance policy" means a policy, contract, or agreement described by Section 1451.102.

(2) "Insured" means an individual who is issued, is a party to, or is a beneficiary under a health insurance policy.

(3) "Insurer" means an insurer, association, or organization described by Section 1451.102.

(4) "Nurse first assistant" has the meaning assigned

1 by Section 301.1525, Occupations Code. (New; V.T.I.C. Art. 21.52,
2 Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 812.)

3 Sec. 1451.102. APPLICABILITY OF SUBCHAPTER. Except as
4 provided by this subchapter, this subchapter applies only to an
5 individual, group, blanket, or franchise insurance policy,
6 insurance agreement, or group hospital service contract that
7 provides health benefits, accident benefits, or health and accident
8 benefits for medical or surgical expenses incurred as a result of an
9 accident or sickness and that is delivered, issued for delivery, or
10 renewed in this state by any incorporated or unincorporated
11 insurance company, association, or organization, including:

12 (1) a fraternal benefit society operating under
13 Chapter 885;

14 (2) a general casualty company operating under Chapter
15 861;

16 (3) a life, health, and accident insurance company
17 operating under Chapter 841 or 982;

18 (4) a Lloyd's plan operating under Chapter 941;

19 (5) a local mutual aid association operating under
20 Chapter 886;

21 (6) a mutual insurance company writing insurance other
22 than life insurance operating under Chapter 883;

23 (7) a mutual life insurance company operating under
24 Chapter 882;

25 (8) a reciprocal exchange operating under Chapter 942;

26 (9) a statewide mutual assessment company, mutual
27 assessment company, or mutual assessment life, health, and accident

1 association operating under Chapter 881 or 887; and

2 (10) a stipulated premium company operating under
3 Chapter 884. (V.T.I.C. Art. 21.52, Secs. 1 (part), 2, 3(a) (part).)

4 Sec. 1451.103. CONFLICTING PROVISIONS VOID. (a) A
5 provision of a health insurance policy that conflicts with this
6 subchapter is void to the extent of the conflict.

7 (b) The presence in a health insurance policy of a provision
8 void under Subsection (a) does not affect the validity of other
9 policy provisions.

10 (c) An insurer shall bring each approved policy form that
11 contains a provision that conflicts with this subchapter into
12 compliance with this subchapter by use of:

13 (1) a rider or endorsement approved by the
14 commissioner; or

15 (2) a new or revised policy form approved by the
16 commissioner. (V.T.I.C. Art. 21.52, Sec. 3(e).)

17 Sec. 1451.104. NONDISCRIMINATORY PAYMENT OR REIMBURSEMENT;
18 EXCEPTION. (a) An insurer may not classify, differentiate, or
19 discriminate between scheduled services or procedures provided by a
20 health care practitioner selected under this subchapter and
21 performed in the scope of that practitioner's license and the same
22 services or procedures provided by another type of health care
23 practitioner whose services or procedures are covered by a health
24 insurance policy, in regard to:

25 (1) the payment schedule or payment provisions of the
26 policy; or

27 (2) the amount or manner of payment or reimbursement

1 under the policy.

2 (b) An insurer may not deny payment or reimbursement for
3 services or procedures in accordance with the policy payment
4 schedule or payment provisions solely because the services or
5 procedures were performed by a health care practitioner selected
6 under this subchapter.

7 (c) Notwithstanding Subsection (a), a health insurance
8 policy may provide for a different amount of payment or
9 reimbursement for scheduled services or procedures performed by an
10 advanced practice nurse, nurse first assistant, licensed surgical
11 assistant, or physician assistant if the methodology used to
12 compute the amount is the same as the methodology used to compute
13 the amount of payment or reimbursement when the services or
14 procedures are provided by a physician. (V.T.I.C. Art. 21.52,
15 Secs. 3(c) (part), (d) (part), as amended Acts 77th Leg., R.S., Chs.
16 812, 1014.)

17 Sec. 1451.105. SELECTION OF ACUPUNCTURIST. An insured may
18 select an acupuncturist to provide the services or procedures
19 scheduled in the health insurance policy that are within the scope
20 of the acupuncturist's license. (V.T.I.C. Art. 21.52, Sec. 3(a)
21 (part).)

22 Sec. 1451.106. SELECTION OF ADVANCED PRACTICE NURSE. An
23 insured may select an advanced practice nurse to provide the
24 services scheduled in the health insurance policy that are within
25 the scope of the nurse's license. (V.T.I.C. Art. 21.52, Sec. 3(a)
26 (part).)

27 Sec. 1451.107. SELECTION OF AUDIOLOGIST. An insured may

1 select an audiologist to measure hearing to determine the presence
2 or extent of the insured's hearing loss or provide aural
3 rehabilitation services to the insured if the insured has a hearing
4 loss and the services or procedures are scheduled in the health
5 insurance policy. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

6 Sec. 1451.108. SELECTION OF CHEMICAL DEPENDENCY COUNSELOR.
7 An insured may select a chemical dependency counselor to provide
8 services or procedures scheduled in the health insurance policy
9 that are within the scope of the counselor's license. (V.T.I.C.
10 Art. 21.52, Sec. 3(a) (part).)

11 Sec. 1451.109. SELECTION OF CHIROPRACTOR. An insured may
12 select a chiropractor to provide the medical or surgical services
13 or procedures scheduled in the health insurance policy that are
14 within the scope of the chiropractor's license. (V.T.I.C. Art.
15 21.52, Sec. 3(a) (part).)

16 Sec. 1451.110. SELECTION OF DENTIST. An insured may select
17 a dentist to provide the medical or surgical services or procedures
18 scheduled in the health insurance policy that are within the scope
19 of the dentist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

20 Sec. 1451.111. SELECTION OF DIETITIAN. An insured may
21 select a licensed dietitian or a provisionally licensed dietitian
22 acting under the supervision of a licensed dietitian to provide the
23 services scheduled in the health insurance policy that are within
24 the scope of the dietitian's license. (V.T.I.C. Art. 21.52, Sec.
25 3(a) (part).)

26 Sec. 1451.112. SELECTION OF HEARING INSTRUMENT FITTER AND
27 DISPENSER. An insured may select a hearing instrument fitter and

1 dispenser to provide the services or procedures scheduled in the
2 health insurance policy that are within the scope of the license of
3 the fitter and dispenser. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

4 Sec. 1451.113. SELECTION OF LICENSED MASTER SOCIAL
5 WORKER--ADVANCED CLINICAL PRACTITIONER. (a) An insured may select
6 a licensed master social worker--advanced clinical practitioner to
7 provide the services or procedures scheduled in the health
8 insurance policy that:

9 (1) are within the scope of the social worker's
10 license, including the provision of direct, diagnostic,
11 preventive, or clinical services to individuals, families, and
12 groups whose functioning is threatened or affected by social or
13 psychological stress or health impairment; and

14 (2) are specified as services under the terms of the
15 health insurance policy.

16 (b) The health insurance policy may require that services of
17 a licensed master social worker--advanced clinical practitioner
18 must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs.
19 3(a) (part), (b) (part).)

20 Sec. 1451.114. SELECTION OF LICENSED PROFESSIONAL
21 COUNSELOR. (a) An insured may select a licensed professional
22 counselor to provide the services scheduled in the health insurance
23 policy that are within the scope of the counselor's license.

24 (b) The health insurance policy may require that services of
25 a licensed professional counselor must be recommended by a
26 physician. (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (part).)

27 Sec. 1451.115. SELECTION OF SURGICAL ASSISTANT. An insured

1 may select a surgical assistant to provide the services or
2 procedures scheduled in the health insurance policy that are within
3 the scope of the assistant's license. (V.T.I.C. Art. 21.52, Sec.
4 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

5 Sec. 1451.116. SELECTION OF MARRIAGE AND FAMILY THERAPIST.

6 (a) An insured may select a marriage and family therapist to
7 provide the services scheduled in the health insurance policy that
8 are within the scope of the therapist's license.

9 (b) The health insurance policy may require that services of
10 a marriage and family therapist must be recommended by a physician.
11 (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (part).)

12 Sec. 1451.117. SELECTION OF NURSE FIRST ASSISTANT. An
13 insured may select a nurse first assistant to provide the services
14 scheduled in the health insurance policy that:

- 15 (1) are within the scope of the nurse's license; and
16 (2) are requested by the physician whom the nurse is
17 assisting. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts
18 77th Leg., R.S., Ch. 812.)

19 Sec. 1451.118. SELECTION OF OCCUPATIONAL THERAPIST. An
20 insured may select an occupational therapist to provide the
21 services scheduled in the health insurance policy that are within
22 the scope of the therapist's license. (V.T.I.C. Art. 21.52, Sec.
23 3(a) (part).)

24 Sec. 1451.119. SELECTION OF OPTOMETRIST. An insured may
25 select an optometrist to provide the services or procedures
26 scheduled in the health insurance policy that are within the scope
27 of the optometrist's license. (V.T.I.C. Art. 21.52, Sec. 3(a)

1 (part).)

2 Sec. 1451.120. SELECTION OF PHYSICAL THERAPIST. An insured
3 may select a physical therapist to provide the services scheduled
4 in the health insurance policy that are within the scope of the
5 therapist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

6 Sec. 1451.121. SELECTION OF PHYSICIAN ASSISTANT. An
7 insured may select a physician assistant to provide the services
8 scheduled in the health insurance policy that are within the scope
9 of the assistant's license. (V.T.I.C. Art. 21.52, Sec. 3(a)
10 (part).)

11 Sec. 1451.122. SELECTION OF PODIATRIST. An insured may
12 select a podiatrist to provide the medical or surgical services or
13 procedures scheduled in the health insurance policy that are within
14 the scope of the podiatrist's license. (V.T.I.C. Art. 21.52, Sec.
15 3(a) (part).)

16 Sec. 1451.123. SELECTION OF PSYCHOLOGICAL ASSOCIATE. An
17 insured may select a psychological associate to provide the
18 services scheduled in the health insurance policy that are within
19 the scope of the associate's license. (V.T.I.C. Art. 21.52, Sec.
20 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

21 Sec. 1451.124. SELECTION OF PSYCHOLOGIST. An insured may
22 select a psychologist to provide the services or procedures
23 scheduled in the health insurance policy that are within the scope
24 of the psychologist's license. (V.T.I.C. Art. 21.52, Sec. 3(a)
25 (part).)

26 Sec. 1451.125. SELECTION OF SPEECH-LANGUAGE PATHOLOGIST.
27 An insured may select a speech-language pathologist to evaluate

1 speech or language, provide habilitative or rehabilitative
2 services to restore speech or language loss, or correct a speech or
3 language impairment if the services or procedures are scheduled in
4 the health insurance policy. (V.T.I.C. Art. 21.52, Sec. 3(a)
5 (part).)

6 Sec. 1451.126. REIMBURSEMENT FOR PHYSICAL MODALITIES AND
7 PROCEDURES BY HEALTH INSURER, ADMINISTRATOR, HEALTH MAINTENANCE
8 ORGANIZATION, OR PREFERRED PROVIDER BENEFIT PLAN ISSUER. (a) A
9 health insurer or licensed third-party administrator may not deny
10 reimbursement to a health care practitioner for the provision of
11 covered services of physical modalities and procedures that are
12 within the scope of the practitioner's practice if the services are
13 performed in strict compliance with:

14 (1) laws and rules related to that practitioner's
15 license; and

16 (2) the terms of the insurance policy or other
17 coverage agreement.

18 (b) A health maintenance organization or preferred provider
19 benefit plan issuer may not deny reimbursement to a participating
20 health care practitioner for services provided under a coverage
21 agreement solely because of the type of practitioner providing the
22 services if the services are performed in strict compliance with:

23 (1) laws and rules related to that practitioner's
24 license; and

25 (2) the terms of the insurance policy or other
26 coverage agreement.

27 (c) This section may not be construed to circumvent any

1 contractual provider network agreement between a health insurer or
2 third-party administrator and a licensed health care practitioner.
3 (V.T.I.C. Art. 21.52, Sec. 3A.)

4 Sec. 1451.127. DUTY OF PERSON ARRANGING PROVIDER CONTRACTS
5 FOR HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION. (a) A
6 person who arranges contracts with providers on behalf of a health
7 maintenance organization or health insurer shall comply with laws
8 related to the duties of the organization or insurer to notify and
9 consider providers for those contracts.

10 (b) A violation of this section:

11 (1) is an unlawful practice under Section 15.05,
12 Business & Commerce Code; and

13 (2) constitutes restraint of trade. (V.T.I.C. Art.
14 21.52, Sec. 4.)

15 [Sections 1451.128-1451.150 reserved for expansion]

16 SUBCHAPTER D. ACCESS TO OPTOMETRISTS AND OPHTHALMOLOGISTS

17 USED UNDER MANAGED CARE PLAN

18 Sec. 1451.151. DEFINITIONS. In this subchapter:

19 (1) "Managed care plan" means a plan under which a
20 health maintenance organization, preferred provider benefit plan
21 issuer, or other organization provides or arranges for health care
22 benefits to plan participants and requires or encourages plan
23 participants to use health care practitioners the plan designates.

24 (2) "Ophthalmologist" means a physician who
25 specializes in ophthalmology. (V.T.I.C. Art. 21.52D, Sec. (a).)

26 Sec. 1451.152. APPLICABILITY AND CONSTRUCTION OF
27 SUBCHAPTER. (a) This subchapter applies only to a managed care

1 plan that provides or arranges for benefits for vision or medical
2 eye care services or procedures that are within the scope of an
3 optometrist's or therapeutic optometrist's license.

4 (b) This subchapter does not require a managed care plan to
5 provide vision or medical eye care services or procedures.
6 (V.T.I.C. Art. 21.52D, Secs. (b) (part), (c).)

7 Sec. 1451.153. USE OF OPTOMETRIST, THERAPEUTIC
8 OPTOMETRIST, OR OPHTHALMOLOGIST. (a) A managed care plan may not:

9 (1) discriminate against a health care practitioner
10 because the practitioner is an optometrist, therapeutic
11 optometrist, or ophthalmologist;

12 (2) restrict or discourage a plan participant from
13 obtaining covered vision or medical eye care services or procedures
14 from a participating optometrist, therapeutic optometrist, or
15 ophthalmologist solely because the practitioner is an optometrist,
16 therapeutic optometrist, or ophthalmologist;

17 (3) exclude an optometrist, therapeutic optometrist,
18 or ophthalmologist as a participating practitioner in the plan
19 because the optometrist, therapeutic optometrist, or
20 ophthalmologist does not have medical staff privileges at a
21 hospital or at a particular hospital; or

22 (4) exclude an optometrist, therapeutic optometrist,
23 or ophthalmologist as a participating practitioner in the plan
24 because the services or procedures provided by the optometrist,
25 therapeutic optometrist, or ophthalmologist may be provided by
26 another type of health care practitioner.

27 (b) A managed health care plan shall:

1 (1) include optometrists, therapeutic optometrists,
2 and ophthalmologists as participating health care practitioners in
3 the plan; and

4 (2) include the name of a participating optometrist,
5 therapeutic optometrist, or ophthalmologist in any list of
6 participating health care practitioners and give equal prominence
7 to each name. (V.T.I.C. Art. 21.52D, Sec. (b) (part).)

8 [Sections 1451.154-1451.200 reserved for expansion]

9 SUBCHAPTER E. DENTAL CARE BENEFITS IN HEALTH INSURANCE

10 POLICIES OR EMPLOYEE BENEFIT PLANS

11 Sec. 1451.201. DEFINITIONS. In this subchapter:

12 (1) "Dental care service" means a service provided to
13 a person to prevent, alleviate, cure, or heal a human dental illness
14 or injury.

15 (2) "Employee benefit plan" means a plan, fund, or
16 program established or maintained by an employer or employee
17 organization.

18 (3) "Health insurance policy" means any individual,
19 group, blanket, or franchise insurance policy, insurance
20 agreement, or group hospital service contract. (V.T.I.C. Art.
21 21.53, Sec. 1 (part).)

22 Sec. 1451.202. APPLICABILITY AND CONSTRUCTION OF
23 SUBCHAPTER. (a) This subchapter applies only to an employee
24 benefit plan or health insurance policy delivered, issued for
25 delivery, renewed, or contracted for in this state to the extent
26 that:

27 (1) the employee benefit plan is established or

1 maintained to provide dental care services, through insurance or
2 otherwise, for the plan's participants or the beneficiaries of the
3 plan's participants; or

4 (2) the health insurance policy provides benefits for
5 dental care services.

6 (b) This subchapter does not apply to a health maintenance
7 organization governed by Chapter 843.

8 (c) The exemptions and exceptions of Sections 881.002 and
9 881.004 and Article 21.41 do not apply to this subchapter.

10 (d) This subchapter does not require an employee benefit
11 plan or health insurance policy to provide any type of benefits for
12 dental care expenses. (V.T.I.C. Art. 21.53, Secs. 1(a) (part), (b)
13 (part), 4 (part), 5, 6.)

14 Sec. 1451.203. CONFLICTING PROVISIONS. A provision of an
15 employee benefit plan or health insurance policy that conflicts
16 with this subchapter is void to the extent of the conflict.
17 (V.T.I.C. Art. 21.53, Sec. 4 (part).)

18 Sec. 1451.204. CERTAIN CONDUCT PERMITTED. (a)
19 Notwithstanding any other provision of this subchapter, a dentist
20 may contract directly with a patient to provide dental care
21 services to the patient as authorized by law.

22 (b) Notwithstanding any other provision of this subchapter,
23 a person providing a health insurance policy or employee benefit
24 plan or an employer or an employee organization may:

25 (1) make information available to its insureds,
26 beneficiaries, participants, employees, or members regarding
27 dental care services through the distribution of factually accurate

1 information about dental care services and the rates, fees,
2 locations, and hours for the services if the information is
3 distributed on the request of a dentist;

4 (2) establish an administrative mechanism to
5 facilitate payments for dental care services from an insured,
6 beneficiary, participant, employee, or member to a dentist chosen
7 by the insured, beneficiary, participant, employee, or member; or

8 (3) nondiscriminatorily pay or reimburse its insured,
9 beneficiary, participant, employee, or member for the cost of
10 dental care services provided by a dentist chosen by the insured,
11 beneficiary, participant, employee, or member. (V.T.I.C. Art.
12 21.53, Sec. 7.)

13 Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS. An employee
14 benefit plan or health insurance policy shall:

15 (1) if applicable, disclose that the benefit for
16 dental care services offered is limited to the least costly
17 treatment; and

18 (2) specify in dollars and cents the amount of the
19 payment or reimbursement to be provided for dental care services or
20 define and explain the standard on which payment of benefits or
21 reimbursement for the cost of dental care services is based, such
22 as:

23 (A) "usual and customary" fees;

24 (B) "reasonable and customary" fees;

25 (C) "usual, customary, and reasonable" fees; or

26 (D) words of similar meaning. (V.T.I.C. Art.
27 21.53, Sec. 3 (part).)

Sec. 1451.206. PAYMENT OR REIMBURSEMENT OF DENTIST. (a)

The employee benefit plan or health insurance policy shall provide:

(1) that payment or reimbursement for a noncontracting provider dentist shall be the same as payment or reimbursement for a contracting provider dentist; and

(2) that the party to or beneficiary of the plan or policy may assign the right to payment or reimbursement to the dentist who provides the dental care services.

(b) Notwithstanding Subsection (a)(1), the employee benefit plan or health insurance policy is not required to make payment or reimbursement in an amount greater than:

(1) the amount specified in the plan or policy; or

(2) the fee the providing dentist charges for the dental care services provided.

(c) If the right to payment or reimbursement is assigned as provided by Subsection (a)(2):

(1) payment or reimbursement shall be made directly to the designated dentist; and

(2) direct payment to the designated dentist discharges the payor's obligation. (V.T.I.C. Art. 21.53, Sec. 3 (part).)

Sec. 1451.207. PROHIBITED CONDUCT. (a) An employee benefit plan or health insurance policy may not:

(1) interfere with or prevent an individual who is a party to or beneficiary of the plan or policy from selecting a dentist of the individual's choice to provide a dental care service the plan or policy offers if the dentist selected is licensed in

1 this state to provide the service;

2 (2) deny a dentist the right to participate as a
3 contracting provider under the plan or policy if the dentist is
4 licensed to provide the dental care services the plan or policy
5 offers;

6 (3) authorize a person to regulate, interfere with, or
7 intervene in the provision of dental care services a dentist
8 provides a patient, including diagnosis, if the dentist practices
9 within the scope of the dentist's license; or

10 (4) require a dentist to make or obtain a dental x-ray
11 or other diagnostic aid in providing dental care services.

12 (b) Subsection (a)(4) does not prohibit a request for an
13 existing dental x-ray or other existing diagnostic aid for a
14 determination of benefits payable under an employee benefit plan or
15 health insurance policy.

16 (c) This section does not prohibit the predetermination of
17 benefits for dental care expenses before the attending dentist
18 provides treatment. (V.T.I.C. Art. 21.53, Sec. 2.)

19 [Sections 1451.208-1451.250 reserved for expansion]

20 SUBCHAPTER F. ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE

21 Sec. 1451.251. DEFINITION. In this subchapter, "enrollee"
22 means an individual enrolled in a health benefit plan. (V.T.I.C.
23 Art. 21.53D, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 912.)

24 Sec. 1451.252. APPLICABILITY OF SUBCHAPTER. This
25 subchapter applies only to a health benefit plan that requires an
26 enrollee to obtain certain specialty health care services through a
27 referral made by a primary care physician or other gatekeeper and

1 that:

2 (1) provides benefits for medical or surgical expenses
3 incurred as a result of a health condition, accident, or sickness,
4 including:

5 (A) an individual, group, blanket, or franchise
6 insurance policy or insurance agreement, a group hospital service
7 contract, or an individual or group evidence of coverage that is
8 offered by:

9 (i) an insurance company;

10 (ii) a group hospital service corporation
11 operating under Chapter 842;

12 (iii) a fraternal benefit society operating
13 under Chapter 885;

14 (iv) a stipulated premium company operating
15 under Chapter 884; or

16 (v) a health maintenance organization
17 operating under Chapter 843; and

18 (B) to the extent permitted by the Employee
19 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
20 seq.), a health benefit plan that is offered by:

21 (i) a multiple employer welfare arrangement
22 as defined by Section 3 of that Act; or

23 (ii) another analogous benefit
24 arrangement;

25 (2) is offered by:

26 (A) an approved nonprofit health corporation
27 that holds a certificate of authority under Chapter 844; or

1 (B) an entity that is not authorized under this
2 code or another insurance law of this state that contracts directly
3 for health care services on a risk-sharing basis, including a
4 capitation basis; or

5 (3) provides health and accident coverage through a
6 risk pool created under Chapter 172, Local Government Code,
7 notwithstanding Section 172.014, Local Government Code, or any
8 other law. (V.T.I.C. Art. 21.53D, Secs. 2(a), (b), (d), as added
9 Acts 75th Leg., R.S., Ch. 912.)

10 Sec. 1451.253. EXCEPTION. This subchapter does not apply
11 to:

12 (1) a plan that provides coverage:

13 (A) only for a specified disease;

14 (B) only for accidental death or dismemberment;

15 (C) for wages or payments instead of wages for a
16 period during which an employee is absent from work because of
17 sickness or injury; or

18 (D) as a supplement to a liability insurance
19 policy;

20 (2) a small employer health benefit plan written under
21 Chapter 1501;

22 (3) a Medicare supplemental policy as defined by
23 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

24 (4) a workers' compensation insurance policy;

25 (5) medical payment insurance coverage provided under
26 a motor vehicle insurance policy;

27 (6) a long-term care insurance policy, including a

1 nursing home fixed indemnity policy, unless the commissioner
2 determines that the policy provides benefit coverage so
3 comprehensive that the policy is a health benefit plan as described
4 by Section 1451.252; or

5 (7) any health benefit plan that does not provide:

6 (A) benefits related to pregnancy; or

7 (B) well-woman care benefits. (V.T.I.C. Art.
8 21.53D, Sec. 2(c), as added Acts 75th Leg., R.S., Ch. 912.)

9 Sec. 1451.254. RULES. The commissioner shall adopt rules
10 necessary to implement this subchapter. (V.T.I.C. Art. 21.53D,
11 Sec. 6, as added Acts 75th Leg., R.S., Ch. 912.)

12 Sec. 1451.255. RIGHT OF FEMALE ENROLLEE TO SELECT
13 OBSTETRICIAN OR GYNECOLOGIST. (a) Except as provided by
14 Subsection (b), a health benefit plan shall permit a female
15 enrollee to select, in addition to a primary care physician, an
16 obstetrician or gynecologist to provide the enrollee with health
17 care services that are within the scope of the professional
18 specialty practice of a properly credentialed obstetrician or
19 gynecologist.

20 (b) A health benefit plan may limit an enrollee's
21 self-referral under Subsection (a) to only one participating
22 obstetrician or gynecologist to provide both gynecological and
23 obstetrical care to the enrollee. This subsection does not affect
24 the right of an enrollee to select the physician who provides that
25 care.

26 (c) This section does not preclude an enrollee from
27 selecting a qualified physician, including a family physician or

1 internal medicine physician, to provide the enrollee with health
2 care services described by Subsection (a).

3 (d) This section does not affect the authority of a health
4 benefit plan issuer to establish selection criteria regarding other
5 physicians who provide services under the plan. (V.T.I.C. Art.
6 21.53D, Secs. 3(a), (c), 4(e), as added Acts 75th Leg., R.S., Ch.
7 912.)

8 Sec. 1451.256. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN OR
9 GYNECOLOGIST. (a) In this section, "health care services"
10 includes:

11 (1) one well-woman examination each year;
12 (2) care related to pregnancy;
13 (3) care for any active gynecological condition; and
14 (4) diagnosis, treatment, and referral for any disease
15 or condition that is within the scope of the professional specialty
16 practice of a properly credentialed obstetrician or gynecologist.

17 (b) In addition to other benefits authorized under the
18 health benefit plan, a health benefit plan shall permit an enrollee
19 who selects an obstetrician or gynecologist under Section 1451.255
20 to have direct access to the health care services of that selected
21 physician without:

22 (1) a referral from the enrollee's primary care
23 physician; or

24 (2) prior authorization or precertification from the
25 plan issuer.

26 (c) A health benefit plan may not impose a copayment or
27 deductible for direct access to health care services as required by

1 this section unless the same copayment or deductible is imposed for
2 access to other health care services provided under the plan.

3 (d) This section does not affect the authority of a health
4 benefit plan issuer to require an obstetrician or gynecologist
5 selected by an enrollee under Section 1451.255 to forward
6 information concerning the medical care of the enrollee to the
7 enrollee's primary care physician. (V.T.I.C. Art. 21.53D, Secs.
8 4(a), (b), (c), (d) (part), as added Acts 75th Leg., R.S., Ch. 912.)

9 Sec. 1451.257. AVAILABILITY OF PROVIDERS. To ensure access
10 to services that are within the scope of the professional specialty
11 practice of a properly credentialed obstetrician or gynecologist, a
12 health benefit plan shall include in the classification of persons
13 authorized to provide medical services under the plan a sufficient
14 number of properly credentialed obstetricians and gynecologists.
15 (V.T.I.C. Art. 21.53D, Sec. 3(b), as added Acts 75th Leg., R.S., Ch.
16 912.)

17 Sec. 1451.258. NOTICE OF AVAILABLE PROVIDERS. (a) A health
18 benefit plan issuer shall provide to each person covered under the
19 plan a timely written notice of the choices of the types of
20 physician providers available for the direct access required under
21 this subchapter.

22 (b) The notice must be stated in clear and accurate
23 language. (V.T.I.C. Art. 21.53D, Sec. 5, as added Acts 75th Leg.,
24 R.S., Ch. 912.)

25 Sec. 1451.259. LIMITS ON PHYSICIAN SANCTIONS. (a) A health
26 benefit plan may not sanction or terminate a primary care physician
27 because of female enrollees' access to participating obstetricians

1 and gynecologists under this subchapter.

2 (b) A health benefit plan may not impose a financial or
3 other penalty on an obstetrician or gynecologist selected under
4 Section 1451.255, or on the enrollee who selected the physician,
5 because the selected physician failed to provide to the enrollee's
6 primary care physician information concerning the medical care of
7 the enrollee if the selected physician made a reasonable good faith
8 effort to forward the information. (V.T.I.C. Art. 21.53D, Secs.
9 4(d) (part), (f), as added Acts 75th Leg., R.S., Ch. 912.)

10 Sec. 1451.260. ADMINISTRATIVE PENALTY. An entity that
11 operates a health benefit plan in violation of this subchapter is
12 subject to an administrative penalty as provided by Chapter 84.
13 (V.T.I.C. Art. 21.53D, Sec. 7, as added Acts 75th Leg., R.S., Ch.
14 912.)

15 [Sections 1451.261-1451.300 reserved for expansion]

16 SUBCHAPTER G. ACCESS TO DIETITIAN SERVICES

17 Sec. 1451.301. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
18 LAW. The provisions of Chapter 1201, including provisions relating
19 to the applicability, purpose, and enforcement of that chapter, the
20 construction of policies under that chapter, rulemaking under that
21 chapter, and definitions of terms applicable in that chapter, apply
22 to this subchapter. (New.)

23 Sec. 1451.302. DIETITIAN SERVICES. An individual or group
24 accident and health insurance policy delivered or issued for
25 delivery in this state may not:

26 (1) exclude or deny coverage for services performed
27 by:

1 (A) a dietitian; or

2 (B) a provisionally licensed dietitian acting
3 under the supervision of a dietitian; or

4 (2) refuse payment or reimbursement for charges for
5 services described by Subdivision (1) if the services:

6 (A) are in the scope of the dietitian's license;

7 (B) are related to an injury or illness the
8 policy covers if the services are scheduled in the policy; and

9 (C) are provided under a professional
10 recommendation of a physician whose treatment or examination for
11 the injury or illness would be covered by the policy and would be
12 payable or reimbursable under the policy. (V.T.I.C. Art. 3.70-2,
13 Sec. (H), as amended Acts 70th Leg., R.S., Ch. 875, Sec. 2.)

14 [Sections 1451.303-1451.350 reserved for expansion]

15 SUBCHAPTER H. DISABILITY CERTIFIED BY PODIATRIST

16 Sec. 1451.351. LOSS OF INCOME BENEFITS FOR DISABILITY
17 TREATABLE BY PODIATRIST. (a) This section applies only to an
18 insurance policy delivered, issued for delivery, or renewed in this
19 state that provides benefits covering loss of income as a result of
20 an acute temporary disability caused by sickness or injury.

21 (b) An insurance policy may not deny payment of benefits
22 described by Subsection (a) solely because the disability is
23 certified or attested to by a podiatrist if the disability is caused
24 by a sickness or injury that may be treated within the scope of the
25 podiatrist's license. (V.T.I.C. Art. 21.52A.)

26 [Sections 1451.352-1451.400 reserved for expansion]

27 SUBCHAPTER I. USE OF OSTEOPATHIC HOSPITAL

1 Sec. 1451.401. CONTRACT WITH OSTEOPATHIC HOSPITAL. A
2 health maintenance organization or preferred provider benefit plan
3 issuer that contracts with a hospital to provide services to
4 covered individuals may not refuse to contract with an osteopathic
5 hospital solely because the hospital is an osteopathic hospital.
6 (V.T.I.C. Art. 21.53B, Sec. (a).)

7 Sec. 1451.402. SERVICES AT OSTEOPATHIC HOSPITAL. A health
8 maintenance organization or preferred provider benefit plan issuer
9 that provides benefits for inpatient or outpatient services
10 provided by an allopathic hospital shall seek to provide benefits
11 for similar services provided by an osteopathic hospital if there
12 is an osteopathic hospital within the service area of the health
13 maintenance organization or preferred provider benefit plan issuer
14 that will provide the services at a substantially similar cost.
15 (V.T.I.C. Art. 21.53B, Sec. (b).)

16 Sec. 1451.403. REQUEST FOR ACTION OF COMMISSIONER. An
17 aggrieved party may request that the commissioner conduct an
18 investigation, review, hearing, or other proceeding to determine
19 compliance with this subchapter. (V.T.I.C. Art. 21.53B, Sec. (c)
20 (part).)

21 Sec. 1451.404. ENFORCEMENT. The commissioner shall take
22 all reasonable actions to ensure compliance with this subchapter,
23 including issuing orders and assessing penalties. (V.T.I.C. Art.
24 21.53B, Sec. (c) (part).)

25 CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

26 SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS

27 BY HEALTH MAINTENANCE ORGANIZATION

1 Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS

2 Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE

3 OR CERTIFICATE

4 Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING

5 Sec. 1452.004. LIMITATION ON COMMISSIONER'S AUTHORITY

6 Sec. 1452.005. SITE VISIT FOR CAUSE NOT PRECLUDED

7 Sec. 1452.006. RULES RELATED TO SELECTION OF PHYSICIANS

8 AND PROVIDERS BY HEALTH MAINTENANCE

9 ORGANIZATION

10 [Sections 1452.007-1452.050 reserved for expansion]

11 SUBCHAPTER B. STANDARDIZED FORMS

12 Sec. 1452.051. DEFINITION

13 Sec. 1452.052. STANDARDIZED FORM FOR VERIFICATION OF

14 PHYSICIAN CREDENTIALS

15 CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

16 SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS

17 BY HEALTH MAINTENANCE ORGANIZATION

18 Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS. In
19 this subchapter, a term defined by Section 843.002 has the meaning
20 assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts
21 77th Leg., R.S., Ch. 1419.)

22 Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE OR
23 CERTIFICATE. The commissioner shall require a health maintenance
24 organization to verify that a physician's license to practice
25 medicine and any other certificate the physician is required to
26 hold, including a certificate issued by the Department of Public
27 Safety or the federal Drug Enforcement Administration or a

1 certificate issued under the Medicare program, is valid as of the
2 date of:

- 3 (1) initial credentialing of the physician; and
4 (2) each recredentialing. (V.T.I.C. Art. 20A.39, Sec.
5 (b).)

6 Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING. (a)
7 The commissioner shall require a health maintenance organization
8 that conducts a site visit for the purpose of initial credentialing
9 of a physician or provider to evaluate during the visit a site's
10 accessibility, appearance, space, medical or dental recordkeeping
11 practices, availability of appointments, and confidentiality
12 procedures.

13 (b) The commissioner may not require the health maintenance
14 organization to evaluate the appropriateness of equipment during
15 the site visit. (V.T.I.C. Art. 20A.39, Sec. (c).)

16 Sec. 1452.004. LIMITATION ON COMMISSIONER'S AUTHORITY. The
17 commissioner may not require a health maintenance organization to:

18 (1) formally recredential a physician or provider more
19 frequently than once in any three-year period;

20 (2) verify the validity of a license or certificate
21 held by a physician as of a date other than the date of initial
22 credentialing or recredentialing of the physician;

23 (3) use clinical personnel to perform a site visit for
24 initial credentialing of a physician or provider unless clinical
25 review is needed during the site visit; or

26 (4) require a site visit be performed for the purpose
27 of recredentialing of a physician or provider. (V.T.I.C. Art.

20A.39, Sec. (d).)

Sec. 1452.005. SITE VISIT FOR CAUSE NOT PRECLUDED. This subchapter does not preclude a health maintenance organization from conducting a site visit of a physician or provider at any time for cause, including a complaint made by a member or another external complaint made to the health maintenance organization. (V.T.I.C. Art. 20A.39, Sec. (e).)

Sec. 1452.006. RULES RELATED TO SELECTION OF PHYSICIANS AND PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION. A rule adopted by the commissioner under Section 843.102 that relates to implementation and maintenance by a health maintenance organization of a process for selecting and retaining affiliated physicians and providers must comply with:

(1) this subchapter; and

(2) standards adopted by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. (V.T.I.C. Art. 20A.39, Sec. (a).)

[Sections 1452.007-1452.050 reserved for expansion]

SUBCHAPTER B. STANDARDIZED FORMS

Sec. 1452.051. DEFINITION. In this subchapter, "physician" means an individual licensed to practice medicine in this state. (V.T.I.C. Art. 21.58D, Sec. 1.)

Sec. 1452.052. STANDARDIZED FORM FOR VERIFICATION OF PHYSICIAN CREDENTIALS. (a) The commissioner by rule shall:

(1) prescribe a standardized form for the verification of a physician's credentials; and

(2) require a public or private hospital, a health

1 maintenance organization operating under Chapter 843, or the issuer
2 of a preferred provider benefit plan under Chapter 1301 to use the
3 form for verification of physician credentials.

4 (b) In prescribing a form under this section, the
5 commissioner shall consider any credentialing application form
6 that is widely used in this state. (V.T.I.C. Art. 21.58D, Sec. 2.)

7 CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES

8 UNDER MANAGED CARE PLAN

9 Sec. 1453.001. DEFINITIONS

10 Sec. 1453.002. PROVISION OF INFORMATION REGARDING

11 REIMBURSEMENT GUIDELINES

12 Sec. 1453.003. RULES

13 CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES

14 UNDER MANAGED CARE PLAN

15 Sec. 1453.001. DEFINITIONS. In this chapter:

16 (1) "Health care provider" means:

17 (A) a hospital, emergency clinic, outpatient
18 clinic, or other facility providing health care services; or

19 (B) an individual who is licensed in this state
20 to provide health care services.

21 (2) "Managed care entity" means:

22 (A) a health maintenance organization;

23 (B) a preferred provider benefit plan issuer;

24 (C) an approved nonprofit health corporation
25 that holds a certificate of authority under Chapter 844; or

26 (D) another entity that offers a managed care
27 plan, including:

- 1 (i) an insurance company;
- 2 (ii) a group hospital service corporation
- 3 operating under Chapter 842;
- 4 (iii) a fraternal benefit society operating
- 5 under Chapter 885;
- 6 (iv) a stipulated premium company operating
- 7 under Chapter 884;
- 8 (v) a multiple employer welfare arrangement
- 9 that holds a certificate of authority under Chapter 846; and
- 10 (vi) an entity not authorized under this
- 11 code or another insurance law of this state that contracts directly
- 12 for health care services on a risk-sharing basis, including a
- 13 capitation basis.

14 (3) "Managed care plan" means a health benefit plan:

15 (A) under which health care services are provided

16 through contracts with health care providers to individuals

17 enrolled in or insured under the plan; and

18 (B) that provides financial incentives to

19 individuals enrolled in or insured under the plan to use health care

20 providers participating in the plan and procedures covered by the

21 plan. (V.T.I.C. Art. 21.60, Sec. 1.)

22 Sec. 1453.002. PROVISION OF INFORMATION REGARDING

23 REIMBURSEMENT GUIDELINES. (a) On the written request of an

24 out-of-network health care provider, a managed care entity shall

25 furnish to the provider a written description of the factors

26 considered by the entity in determining the amount of reimbursement

27 the provider may receive for goods or services provided to an

1 individual enrolled in or insured under the entity's managed care
2 plan.

3 (b) This section does not require a managed care entity to
4 disclose proprietary information that is prohibited from
5 disclosure by a contract between the entity and a vendor that
6 supplies payment or statistical data to the entity.

7 (c) A contract between a managed care entity and a vendor
8 that supplies payment or statistical data to the entity may not
9 prohibit the entity from disclosing under this section:

10 (1) the name of the vendor; or

11 (2) the methodology and origin of information used to
12 determine the amount of reimbursement.

13 (d) A managed care entity that denies a request for
14 information described by Subsection (b) shall send a copy of the
15 request and the information requested to the department for review.
16 (V.T.I.C. Art. 21.60, Sec. 2.)

17 Sec. 1453.003. RULES. The commissioner shall adopt rules
18 as necessary to implement this chapter. (V.T.I.C. Art. 21.60, Sec.
19 3.)

20 CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

21 SUBCHAPTER A. GENERAL PROVISIONS

22 Sec. 1454.001. DEFINITIONS

23 Sec. 1454.002. APPLICABILITY OF CHAPTER

24 [Sections 1454.003-1454.050 reserved for expansion]

25 SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

26 Sec. 1454.051. EQUAL REIMBURSEMENT REQUIRED

27 Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED

[Sections 1454.053-1454.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Sec. 1454.101. SANCTIONS AUTHORIZED

Sec. 1454.102. CEASE AND DESIST PROCEDURES AND RESTITUTION
FOR ATTORNEY'S FEES AUTHORIZED

Sec. 1454.103. ADMINISTRATIVE PENALTIES AUTHORIZED

Sec. 1454.104. AMOUNT OF DAMAGES

Sec. 1454.105. APPLICABILITY OF CERTAIN PROCEDURAL
REQUIREMENTS TO SANCTIONS OR ADMINISTRATIVE
PENALTIES

Sec. 1454.106. INTERVENTION IN PROCEEDING

Sec. 1454.107. TIME FOR COMMISSIONER'S DETERMINATION

Sec. 1454.108. FAILURE OF COMMISSIONER TO MAKE DETERMINATION
BY ORDER; ACTION IN DISTRICT COURT

Sec. 1454.109. APPEAL OF COMMISSIONER'S ORDER

CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1454.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means a home health aide,
hospital, nurse practitioner, nurse midwife, outpatient care
center, physician assistant, registered nurse, or surgery center.

(2) "Physician" has the meaning assigned by Section
151.002, Occupations Code. (V.T.I.C. Art. 21.53N, Sec. 1.)

Sec. 1454.002. APPLICABILITY OF CHAPTER. This chapter
applies only to a health benefit plan that provides benefits for
medical or surgical expenses incurred as a result of a health
condition, accident, or sickness, including an individual, group,

1 blanket, or franchise insurance policy or insurance agreement, a
2 group hospital service contract, or an individual or group evidence
3 of coverage or similar coverage document that is offered by:

4 (1) an insurance company;

5 (2) a group hospital service corporation operating
6 under Chapter 842;

7 (3) a fraternal benefit society operating under
8 Chapter 885;

9 (4) a stipulated premium company operating under
10 Chapter 884;

11 (5) a reciprocal exchange operating under Chapter 942;

12 (6) a health maintenance organization operating under
13 Chapter 843;

14 (7) a multiple employer welfare arrangement that holds
15 a certificate of authority under Chapter 846;

16 (8) an approved nonprofit health corporation that
17 holds a certificate of authority under Chapter 844; or

18 (9) a small employer health benefit plan written under
19 Chapter 1501. (V.T.I.C. Art. 21.53N, Sec. 2.)

20 [Sections 1454.003-1454.050 reserved for expansion]

21 SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

22 Sec. 1454.051. EQUAL REIMBURSEMENT REQUIRED. A health
23 benefit plan issuer that reimburses a physician or health care
24 provider for reproductive health or oncology services provided to
25 women must reimburse the physician or provider in an amount at least
26 equal to the annual average compensation per hour or unit that would
27 be paid in the service area to a physician or provider for the same

1 medical, surgical, hospital, pharmaceutical, nursing, or other
2 similar resources used to provide the services if the resources
3 would be used to provide health services exclusively to men or to
4 the general population. (V.T.I.C. Art. 21.53N, Sec. 3.)

5 Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED.
6 This chapter does not require a health benefit plan issuer to
7 provide reimbursement for an abortion, as defined by the Family
8 Code, or for a service related to an abortion. (V.T.I.C. Art.
9 21.53N, Sec. 6.)

10 [Sections 1454.053-1454.100 reserved for expansion]

11 SUBCHAPTER C. ENFORCEMENT

12 Sec. 1454.101. SANCTIONS AUTHORIZED. The sanctions
13 authorized by Chapter 82 apply to a health benefit plan issuer that
14 violates this chapter. (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

15 Sec. 1454.102. CEASE AND DESIST PROCEDURES AND RESTITUTION
16 FOR ATTORNEY'S FEES AUTHORIZED. The commissioner may use the cease
17 and desist procedures authorized by Chapter 83 against a health
18 benefit plan issuer that violates this chapter. In accordance with
19 Chapter 83, the commissioner may order the health benefit plan
20 issuer to make complete restitution for the violation, which may
21 include restitution for the reasonable attorney's fees incurred by
22 a person making a complaint under this chapter. (V.T.I.C. Art.
23 21.53N, Sec. 4(a) (part).)

24 Sec. 1454.103. ADMINISTRATIVE PENALTIES AUTHORIZED. (a)
25 In addition to any sanctions authorized by this subchapter, the
26 commissioner may impose an administrative penalty in accordance
27 with Chapter 84 on a health benefit plan issuer that violates this

1 chapter.

2 (b) On a finding that a health benefit plan issuer knowingly
3 violated this chapter, the commissioner may impose in addition to
4 the administrative penalty authorized by Section 84.022 an
5 administrative penalty that does not exceed \$25,000. (V.T.I.C.
6 Art. 21.53N, Sec. 4(b).)

7 Sec. 1454.104. AMOUNT OF DAMAGES. Notwithstanding this
8 subchapter, in imposing a sanction or penalty for a violation of
9 this chapter, the commissioner may order a health benefit plan
10 issuer to pay the greater of complete or economic damages.
11 (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

12 Sec. 1454.105. APPLICABILITY OF CERTAIN PROCEDURAL
13 REQUIREMENTS TO SANCTIONS OR ADMINISTRATIVE PENALTIES. Subchapter
14 C, Chapter 84, applies to the imposition of a sanction or
15 administrative penalty under this chapter. (V.T.I.C. Art. 21.53N,
16 Sec. 4(d).)

17 Sec. 1454.106. INTERVENTION IN PROCEEDING. (a) In a
18 proceeding relating to the imposition by the commissioner of a
19 sanction or administrative penalty under this chapter, a person
20 affected by an order of the commissioner, including a physician or
21 health care provider, may intervene in the proceeding by filing a
22 notice of intervention with the commissioner. The commissioner
23 shall provide an affected person a reasonable period to intervene.

24 (b) At the time the commissioner notifies a health benefit
25 plan issuer of the issuer's opportunity for a hearing regarding an
26 alleged violation, the commissioner shall notify each affected
27 person of all relevant information regarding the hearing.

1 (c) A person who intervenes under this section has the
2 rights and powers of a party under Chapter 2001, Government Code.
3 (V.T.I.C. Art. 21.53N, Sec. 4(e).)

4 Sec. 1454.107. TIME FOR COMMISSIONER'S DETERMINATION. Not
5 later than the 120th day after the date a complaint alleging a
6 violation of this chapter is filed with the department, the
7 commissioner shall determine whether the alleged violation
8 occurred and impose appropriate sanctions. (V.T.I.C. Art. 21.53N,
9 Sec. 4(c).)

10 Sec. 1454.108. FAILURE OF COMMISSIONER TO MAKE
11 DETERMINATION BY ORDER; ACTION IN DISTRICT COURT. (a) If the
12 commissioner fails to determine by order in the time prescribed by
13 Section 1454.107 whether a violation alleged in a complaint filed
14 under this chapter occurred, the person who filed the complaint may
15 bring an action in district court for the violation.

16 (b) The action must be commenced not later than the first
17 anniversary of the date by which the commissioner is required to
18 make a determination under Section 1454.107.

19 (c) In an action filed under this section, a court may:

20 (1) impose the sanctions authorized by this subchapter
21 or similar sanctions;

22 (2) assess an additional civil penalty of \$25,000 if
23 the trier of fact finds the defendant knowingly violated this
24 chapter; and

25 (3) award a claimant who prevails in an action filed
26 under this section reasonable attorney's fees and court costs,
27 including reasonable and necessary expert witness fees.

(d) On a finding by the court that an action filed under this section was groundless and brought in bad faith or brought for the purpose of harassment, the court shall award the defendant reasonable and necessary attorney's fees. (V.T.I.C. Art. 21.53N, Secs. 5(b), (c), (d).)

Sec. 1454.109. APPEAL OF COMMISSIONER'S ORDER. (a) A person affected by an order of the commissioner regarding a violation of this chapter, including a person who intervenes under Section 1454.106, may file an appeal in district court.

(b) The standard of review for an appeal filed under this section is substantial evidence. (V.T.I.C. Art. 21.53N, Sec. 5(a).)

CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

Sec. 1455.001. DEFINITIONS

Sec. 1455.002. APPLICABILITY OF CHAPTER

Sec. 1455.003. EXCEPTION

Sec. 1455.004. COVERAGE FOR TELEMEDICINE MEDICAL SERVICES

AND TELEHEALTH SERVICES

Sec. 1455.005. RULES

CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

Sec. 1455.001. DEFINITIONS. In this chapter:

(1) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to perform health care services; and

(ii) authorized to assist a physician in

1 providing telemedicine medical services that are delegated and
2 supervised by the physician; or

3 (C) a licensed or certified health professional
4 acting within the scope of the license or certification who does not
5 perform a telemedicine medical service.

6 (2) "Physician" means a person licensed to practice
7 medicine in this state under Subtitle B, Title 3, Occupations Code.

8 (3) "Telehealth service" and "telemedicine medical
9 service" have the meanings assigned by Section 57.042, Utilities
10 Code. (V.T.I.C. Art. 21.53F, Secs. 1(2), (3), (4), (5), as added
11 Acts 75th Leg., R.S., Ch. 880.)

12 Sec. 1455.002. APPLICABILITY OF CHAPTER. This chapter
13 applies only to a health benefit plan that:

14 (1) provides benefits for medical or surgical expenses
15 incurred as a result of a health condition, accident, or sickness,
16 including:

17 (A) an individual, group, blanket, or franchise
18 insurance policy or insurance agreement, a group hospital service
19 contract, or an individual or group evidence of coverage that is
20 offered by:

21 (i) an insurance company;
22 (ii) a group hospital service corporation
23 operating under Chapter 842;

24 (iii) a fraternal benefit society operating
25 under Chapter 885;

26 (iv) a stipulated premium company operating
27 under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th Leg., R.S., Ch. 880.)

Sec. 1455.003. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

1 (5) medical payment insurance coverage provided under
2 a motor vehicle insurance policy; or

3 (6) a long-term care insurance policy, including a
4 nursing home fixed indemnity policy, unless the commissioner
5 determines that the policy provides benefit coverage so
6 comprehensive that the policy is a health benefit plan as described
7 by Section 1455.002. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added
8 Acts 75th Leg., R.S., Ch. 880.)

9 Sec. 1455.004. COVERAGE FOR TELEMEDICINE MEDICAL SERVICES
10 AND TELEHEALTH SERVICES. (a) A health benefit plan may not exclude
11 a telemedicine medical service or a telehealth service from
12 coverage under the plan solely because the service is not provided
13 through a face-to-face consultation.

14 (b) A health benefit plan may require a deductible, a
15 copayment, or coinsurance for a telemedicine medical service or a
16 telehealth service. The amount of the deductible, copayment, or
17 coinsurance may not exceed the amount of the deductible, copayment,
18 or coinsurance required for a comparable medical service provided
19 through a face-to-face consultation. (V.T.I.C. Art. 21.53F, Sec.
20 3, as added Acts 75th Leg., R.S., Ch. 880.)

21 Sec. 1455.005. RULES. Subject to Section 107.004,
22 Occupations Code, the commissioner may adopt rules necessary to
23 implement this chapter. (V.T.I.C. Art. 21.53F, Sec. 6(a), as added
24 Acts 75th Leg., R.S., Ch. 880.)

25 [Chapters 1456-1500 reserved for expansion]

26 SUBTITLE G. HEALTH COVERAGE AVAILABILITY

27 CHAPTER 1501. HEALTH INSURANCE PORTABILITY

AND AVAILABILITY ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1501.001. SHORT TITLE

Sec. 1501.002. DEFINITIONS

Sec. 1501.003. APPLICABILITY: SMALL EMPLOYER HEALTH
BENEFIT PLANS

Sec. 1501.004. APPLICABILITY: LARGE EMPLOYER HEALTH
BENEFIT PLANS

Sec. 1501.005. EXCEPTION: CERTAIN INDIVIDUALLY
UNDERWRITTEN POLICIES

Sec. 1501.006. CERTIFICATION

Sec. 1501.007. AFFILIATES

Sec. 1501.008. LATE ENROLLEES

Sec. 1501.009. SCHOOL DISTRICT ELECTION

Sec. 1501.010. GENERAL RULES

Sec. 1501.011. DETERMINATION OF EMPLOYER STATUS FOR
CERTAIN EMPLOYERS

[Sections 1501.012-1501.050 reserved for expansion]

SUBCHAPTER B. PURCHASING COOPERATIVES

Sec. 1501.051. DEFINITIONS

Sec. 1501.052. TEXAS HEALTH BENEFITS PURCHASING
COOPERATIVE; BOARD OF TRUSTEES

Sec. 1501.053. TEXAS HEALTH BENEFITS PURCHASING
COOPERATIVE: EXECUTIVE DIRECTOR AND
OTHER EMPLOYEES

Sec. 1501.054. REGIONAL SUBDIVISIONS OF TEXAS HEALTH
BENEFITS PURCHASING COOPERATIVE

1 Sec. 1501.055. APPLICABILITY OF PUBLIC INFORMATION LAW TO
2 TEXAS HEALTH BENEFITS PURCHASING
3 COOPERATIVE

4 Sec. 1501.056. PRIVATE PURCHASING COOPERATIVES

5 Sec. 1501.057. IMMUNITY

6 Sec. 1501.058. POWERS AND DUTIES OF COOPERATIVES

7 Sec. 1501.059. SELF-INSURED OR SELF-FUNDED PLAN
8 PROHIBITED

9 Sec. 1501.060. SCOPE OF GROUP COVERAGE

10 Sec. 1501.061. REQUIREMENTS APPLICABLE TO HEALTH BENEFIT
11 PLAN ISSUERS WITH WHICH COOPERATIVE
12 MAY CONTRACT

13 Sec. 1501.062. COOPERATIVE NOT INSURER; AGENTS AND
14 ADMINISTRATORS

15 Sec. 1501.063. COOPERATIVE AS EMPLOYER

16 Sec. 1501.064. CERTAIN USE OF APPROPRIATED MONEY
17 PROHIBITED

18 [Sections 1501.065-1501.100 reserved for expansion]

19 SUBCHAPTER C. PROVISION OF COVERAGE

20 Sec. 1501.101. GEOGRAPHIC SERVICE AREAS

21 Sec. 1501.102. PREEXISTING CONDITION PROVISION

22 Sec. 1501.103. TREATMENT OF CERTAIN CONDITIONS AS
23 PREEXISTING PROHIBITED

24 Sec. 1501.104. AFFILIATION PERIOD

25 Sec. 1501.105. WAITING PERIOD PERMITTED

26 Sec. 1501.106. CERTAIN LIMITATIONS OR EXCLUSIONS OF
27 COVERAGE PROHIBITED

1 Sec. 1501.107. DISCOUNTS, REBATES, AND REDUCTIONS

2 Sec. 1501.108. RENEWABILITY OF COVERAGE; CANCELLATION

3 Sec. 1501.109. REFUSAL TO RENEW; DISCONTINUATION OF
4 COVERAGE

5 Sec. 1501.110. NOTICE TO COVERED PERSONS

6 Sec. 1501.111. WRITTEN STATEMENT OF DENIAL, CANCELLATION,
7 OR REFUSAL TO RENEW REQUIRED

8 [Sections 1501.112-1501.150 reserved for expansion]

9 SUBCHAPTER D. GUARANTEED ISSUE OF SMALL EMPLOYER
10 HEALTH BENEFIT PLANS; CONTINUATION OF COVERAGE

11 Sec. 1501.151. GUARANTEED ISSUE

12 Sec. 1501.152. EXCLUSION OF ELIGIBLE EMPLOYEE OR
13 DEPENDENT PROHIBITED

14 Sec. 1501.153. EMPLOYER CONTRIBUTION

15 Sec. 1501.154. MINIMUM PARTICIPATION REQUIREMENT

16 Sec. 1501.155. EXCEPTION TO MINIMUM PARTICIPATION
17 REQUIREMENT

18 Sec. 1501.156. EMPLOYEE ENROLLMENT; WAITING PERIOD

19 Sec. 1501.157. COVERAGE FOR NEWBORN CHILDREN

20 Sec. 1501.158. COVERAGE FOR ADOPTED CHILDREN

21 Sec. 1501.159. CONTINUATION OF COVERAGE FOR CERTAIN
22 DEPENDENTS

23 [Sections 1501.160-1501.200 reserved for expansion]

24 SUBCHAPTER E. UNDERWRITING AND RATING OF
25 SMALL EMPLOYER HEALTH BENEFIT PLANS

26 Sec. 1501.201. DEFINITIONS

27 Sec. 1501.202. ESTABLISHMENT OF CLASSES OF BUSINESS

1 Sec. 1501.203. ESTABLISHMENT OF CLASSES OF BUSINESS ON
2 CERTAIN BASES PROHIBITED
3 Sec. 1501.204. INDEX RATES
4 Sec. 1501.205. PREMIUM RATES: ESTABLISHMENT
5 Sec. 1501.206. PREMIUM RATES: ADJUSTMENTS
6 Sec. 1501.207. PREMIUM RATE ADJUSTMENT IN CLOSED PLAN
7 Sec. 1501.208. PREMIUM RATES: INDUSTRY CLASSIFICATION
8 Sec. 1501.209. PREMIUM RATES: NUMBER OF EMPLOYEES
9 Sec. 1501.210. PREMIUM RATES: NONDISCRIMINATION
10 Sec. 1501.211. RULES CONCERNING PREMIUM RATES
11 Sec. 1501.212. RESTRICTED PROVIDER NETWORK
12 Sec. 1501.213. PREMIUM RATES: HEALTH MAINTENANCE
13 ORGANIZATION HEALTH BENEFIT PLAN
14 Sec. 1501.214. ENFORCEMENT
15 Sec. 1501.215. REPORTING REQUIREMENTS
16 [Sections 1501.216-1501.250 reserved for expansion]
17 SUBCHAPTER F. COVERAGE UNDER SMALL EMPLOYER HEALTH
18 BENEFIT PLANS
19 Sec. 1501.251. EXCEPTION FROM CERTAIN MANDATED BENEFIT
20 REQUIREMENTS
21 Sec. 1501.252. HEALTH BENEFIT PLANS
22 Sec. 1501.253. COVERAGE REQUIREMENTS
23 Sec. 1501.254. ALCOHOL AND SUBSTANCE ABUSE BENEFITS
24 Sec. 1501.255. HEALTH MAINTENANCE ORGANIZATION PLANS
25 Sec. 1501.256. COORDINATION WITH FEDERAL LAW
26 Sec. 1501.257. COST CONTAINMENT
27 Sec. 1501.258. FORMS

1 Sec. 1501.259. RIDERS; FILING WITH COMMISSIONER

2 Sec. 1501.260. PLAIN LANGUAGE REQUIRED

3 [Sections 1501.261-1501.300 reserved for expansion]

4 SUBCHAPTER G. REINSURANCE FOR SMALL EMPLOYER

5 HEALTH BENEFIT PLANS

6 Sec. 1501.301. DEFINITIONS

7 Sec. 1501.302. TEXAS HEALTH REINSURANCE SYSTEM

8 Sec. 1501.303. SYSTEM BOARD OF DIRECTORS

9 Sec. 1501.304. OPEN MEETINGS; PUBLIC INFORMATION

10 Sec. 1501.305. BOARD MEMBER IMMUNITY

11 Sec. 1501.306. SYSTEM PLAN OF OPERATION

12 Sec. 1501.307. SYSTEM POWERS

13 Sec. 1501.308. SYSTEM NOTES AS LEGAL INVESTMENT FOR SMALL

14 EMPLOYER HEALTH BENEFIT PLAN ISSUER

15 Sec. 1501.309. SYSTEM AUDIT

16 Sec. 1501.310. ELECTION OF STATUS

17 Sec. 1501.311. CHANGE IN STATUS

18 Sec. 1501.312. APPLICATION TO OPERATE AS RISK-ASSUMING

19 HEALTH BENEFIT PLAN ISSUER

20 Sec. 1501.313. RESCISSION OF APPROVAL TO OPERATE AS

21 RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER

22 Sec. 1501.314. REINSURANCE

23 Sec. 1501.315. LIMITS ON REINSURANCE

24 Sec. 1501.316. TERMINATION OF REINSURANCE

25 Sec. 1501.317. APPLICATION OF MANAGED CARE PROCEDURES

26 Sec. 1501.318. PREMIUM RATES FOR REINSURANCE

27 Sec. 1501.319. DETERMINATION OF NET LOSS

1 Sec. 1501.320. ASSESSMENTS TO RECOVER NET LOSSES

2 Sec. 1501.321. LIMITS ON ASSESSMENTS

3 Sec. 1501.322. ADJUSTMENT TO ASSESSMENTS ON FEDERALLY

4 QUALIFIED HEALTH MAINTENANCE

5 ORGANIZATIONS

6 Sec. 1501.323. ADVANCE INTERIM ASSESSMENTS

7 Sec. 1501.324. LIMIT ON TOTAL ASSESSMENTS

8 Sec. 1501.325. ESTIMATE OF ASSESSMENTS; EVALUATION AND

9 PROTECTION OF SYSTEM

10 Sec. 1501.326. DEFERMENT OF ASSESSMENT

11 [Sections 1501.327-1501.350 reserved for expansion]

12 SUBCHAPTER H. MARKETING OF

13 SMALL EMPLOYER HEALTH BENEFIT PLANS

14 Sec. 1501.351. MARKETING REQUIREMENTS

15 Sec. 1501.352. HEALTH STATUS AND CLAIMS EXPERIENCE;

16 PROHIBITED ACTS

17 Sec. 1501.353. AGENT COMPENSATION

18 Sec. 1501.354. REQUIRED DISCLOSURES

19 Sec. 1501.355. RULES CONCERNING MARKETING AND

20 AVAILABILITY

21 Sec. 1501.356. REPORTING REQUIREMENTS

22 Sec. 1501.357. VIOLATIONS

23 Sec. 1501.358. APPLICABILITY TO THIRD-PARTY

24 ADMINISTRATOR

25 [Subchapters I-L reserved for expansion]

26 SUBCHAPTER M. LARGE EMPLOYER HEALTH BENEFIT PLANS

27 Sec. 1501.601. PARTICIPATION CRITERIA

1 Sec. 1501.602. COVERAGE REQUIREMENTS

2 Sec. 1501.603. EXCLUSION OF ELIGIBLE EMPLOYEE OR
3 DEPENDENT PROHIBITED

4 Sec. 1501.604. DECLINING COVERAGE

5 Sec. 1501.605. MINIMUM CONTRIBUTION OR PARTICIPATION
6 REQUIREMENTS

7 Sec. 1501.606. EMPLOYEE ENROLLMENT; WAITING PERIOD

8 Sec. 1501.607. COVERAGE FOR NEWBORN CHILDREN

9 Sec. 1501.608. COVERAGE FOR ADOPTED CHILDREN

10 Sec. 1501.609. COVERAGE FOR UNMARRIED CHILDREN

11 Sec. 1501.610. PREMIUM RATES; ADJUSTMENTS

12 Sec. 1501.611. MARKETING REQUIREMENTS

13 Sec. 1501.612. ENCOURAGING EXCLUSION OF EMPLOYEE
14 PROHIBITED

15 Sec. 1501.613. AGENTS

16 Sec. 1501.614. REPORTING OF CLAIMS INFORMATION

17 Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS

18 Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR

19 CHAPTER 1501. HEALTH INSURANCE PORTABILITY
20 AND AVAILABILITY ACT

21 SUBCHAPTER A. GENERAL PROVISIONS

22 Sec. 1501.001. SHORT TITLE. This chapter may be cited as
23 the Health Insurance Portability and Availability Act. (V.T.I.C.
24 Art. 26.01.)

25 Sec. 1501.002. DEFINITIONS. In this chapter:

26 (1) "Agent" means a person who may act as an agent for
27 the sale of a health benefit plan under a license issued under Title

13.

(2) "Dependent" means:

(A) a spouse;

(B) a child younger than 25 years of age, including a newborn child;

(C) a child of any age who is:

(i) medically certified as disabled; and

(ii) dependent on the parent;

(D) an individual who must be covered under:

(i) Section 1251.154; or

(ii) Section 1201.062; and

(E) any other child eligible under an employer's health benefit plan, including a child described by Section 1503.003.

(3) "Eligible employee" means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an employee under a health benefit plan of a small or large employer. The term does not include an employee who:

(A) works on a part-time, temporary, seasonal, or substitute basis;

(B) is covered under:

(i) another health benefit plan; or

(ii) a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income

1 Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or

2 (C) elects not to be covered under the employer's
3 health benefit plan and is covered under:

4 (i) the Medicaid program;

5 (ii) another federal program, including the
6 CHAMPUS program or Medicare program; or

7 (iii) a benefit plan established in another
8 country.

9 (4) "Employee" means an individual employed by an
10 employer.

11 (5) "Health benefit plan" means a group, blanket, or
12 franchise insurance policy, a certificate issued under a group
13 policy, a group hospital service contract, or a group subscriber
14 contract or evidence of coverage issued by a health maintenance
15 organization that provides benefits for health care services. The
16 term does not include:

17 (A) accident-only or disability income insurance
18 coverage or a combination of accident-only and disability income
19 insurance coverage;

20 (B) credit-only insurance coverage;

21 (C) disability insurance coverage;

22 (D) coverage for a specified disease or illness;

23 (E) Medicare services under a federal contract;

24 (F) Medicare supplement and Medicare Select
25 benefit plans regulated in accordance with federal law;

26 (G) long-term care coverage or benefits, nursing
27 home care coverage or benefits, home health care coverage or

1 benefits, community-based care coverage or benefits, or any
2 combination of those coverages or benefits;

3 (H) coverage that provides limited-scope dental
4 or vision benefits;

5 (I) coverage provided by a single service health
6 maintenance organization;

7 (J) workers' compensation insurance coverage or
8 similar insurance coverage;

9 (K) coverage provided through a jointly managed
10 trust authorized under 29 U.S.C. Section 141 et seq. that contains a
11 plan of benefits for employees that is negotiated in a collective
12 bargaining agreement governing wages, hours, and working
13 conditions of the employees that is authorized under 29 U.S.C.
14 Section 157;

15 (L) hospital indemnity or other fixed indemnity
16 insurance coverage;

17 (M) reinsurance contracts issued on a stop-loss,
18 quota-share, or similar basis;

19 (N) short-term major medical contracts;

20 (O) liability insurance coverage, including
21 general liability insurance coverage and automobile liability
22 insurance coverage, and coverage issued as a supplement to
23 liability insurance coverage, including automobile medical payment
24 insurance coverage;

25 (P) coverage for on-site medical clinics;

26 (Q) coverage that provides other limited
27 benefits specified by federal regulations; or

(R) other coverage that:

(i) is similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and

(ii) is specified by federal regulations.

(6) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(7) "Health status related factor" means:

(A) health status;

(B) medical condition, including both physical and mental illness;

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability, including conditions arising out of acts of family violence; and

(H) disability.

1 (8) "Large employer" means a person who employed an
2 average of at least 51 eligible employees on business days during
3 the preceding calendar year and who employs at least two employees
4 on the first day of the plan year. The term includes a governmental
5 entity subject to Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to
6 Subchapter C, Chapter 1364, or to Chapter 1578 that otherwise meets
7 the requirements of this subdivision. For purposes of this
8 definition, a partnership is the employer of a partner.

9 (9) "Large employer health benefit plan" means a
10 health benefit plan offered to a large employer.

11 (10) "Large employer health benefit plan issuer" means
12 a health benefit plan issuer, to the extent that the issuer is
13 offering, delivering, issuing for delivery, or renewing health
14 benefit plans subject to Subchapters C and M.

15 (11) "Person" means an individual, corporation,
16 partnership, or other legal entity.

17 (12) "Preexisting condition provision" means a
18 provision that excludes or limits coverage as to a disease or
19 condition for a specified period after the effective date of
20 coverage.

21 (13) "Premium" means all amounts paid by a small or
22 large employer and eligible employees as a condition of receiving
23 coverage from a small or large employer health benefit plan issuer,
24 including any fees or other contributions associated with a health
25 benefit plan.

26 (14) "Small employer" means a person who employed an
27 average of at least two employees but not more than 50 eligible

1 employees on business days during the preceding calendar year and
2 who employs at least two employees on the first day of the plan
3 year. The term includes a governmental entity subject to Article
4 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364,
5 or to Chapter 1578 that otherwise meets the requirements of this
6 subdivision. For purposes of this definition, a partnership is the
7 employer of a partner.

8 (15) "Small employer health benefit plan" means a
9 health benefit plan developed by the commissioner under Subchapter
10 F or any other health benefit plan offered to a small employer in
11 accordance with Section 1501.252(c) or 1501.255.

12 (16) "Small employer health benefit plan issuer" means
13 a health benefit plan issuer, to the extent that the issuer is
14 offering, delivering, issuing for delivery, or renewing health
15 benefit plans subject to Subchapters C-H.

16 (17) "Waiting period" means a period established by an
17 employer that must elapse before an individual who is a potential
18 enrollee in a health benefit plan is eligible to be covered for
19 benefits. (V.T.I.C. Art. 26.02, Subdivs. (2), (8), (9), (10),
20 (11), (12), (13), (15), (16), (17), (21), (24), (25); Art. 26.02,
21 Subdivs. (30), (31), (32), (34), as amended Acts 77th Leg., R.S.,
22 Ch. 823; Art. 26.02, Subdivs. (29), (30), (31), (33), as amended
23 Acts 77th Leg., R.S., Ch. 608.)

24 Sec. 1501.003. APPLICABILITY: SMALL EMPLOYER HEALTH
25 BENEFIT PLANS. An individual or group health benefit plan is a
26 small employer health benefit plan subject to Subchapters C-H if it
27 provides health care benefits covering two or more eligible

employees of a small employer and:

(1) the employer pays a portion of the premium or benefits;

(2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C. Art. 26.06, Subsec. (a).)

Sec. 1501.004. APPLICABILITY: LARGE EMPLOYER HEALTH BENEFIT PLANS. An individual or group health benefit plan is a large employer health benefit plan subject to Subchapters C and M if the plan provides health care benefits to eligible employees of a large employer and:

(1) the employer pays a portion of the premium or benefits;

(2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C. Art. 26.81, Subsec. (a).)

Sec. 1501.005. EXCEPTION: CERTAIN INDIVIDUALLY UNDERWRITTEN POLICIES. Except as provided by Section 1501.003 or 1501.004, this chapter does not apply to an individual health

1 insurance policy that is subject to individual underwriting, even
2 if the premium is paid through a payroll deduction method.
3 (V.T.I.C. Art. 26.06, Subsec. (c); Art. 26.81, Subsec. (c).)

4 Sec. 1501.006. CERTIFICATION. (a) In accordance with
5 rules adopted by the commissioner, each health benefit plan issuer
6 shall certify that the issuer is offering, delivering, issuing for
7 delivery, or renewing, or that the issuer intends to offer,
8 deliver, issue for delivery, or renew:

9 (1) a health benefit plan to or through a small
10 employer in this state that is subject to this chapter; or

11 (2) a health benefit plan to or through a large
12 employer in this state that is subject to this chapter.

13 (b) A health benefit plan issuer must submit a revised
14 certification to the commissioner only if the issuer changes its
15 status as a small or large employer health benefit plan issuer or
16 changes its intent to become a small or large employer health
17 benefit plan issuer to the extent that its previous certification
18 ceases to be accurate.

19 (c) The certification must include a statement that the
20 health benefit plan issuer is complying with this chapter to the
21 extent it applies to the issuer. (V.T.I.C. Arts. 26.07, 26.82.)

22 Sec. 1501.007. AFFILIATES. (a) In this section,
23 "affiliate" has the meaning described by Section 823.003.

24 (b) For purposes of this chapter, health benefit plan
25 issuers that are affiliates or that are eligible to file a
26 consolidated tax return are considered to be one issuer, and a
27 restriction imposed by this chapter applies as if the health

1 benefit plans delivered or issued for delivery to small employers
2 in this state by the affiliates were issued by one issuer.

3 (c) Notwithstanding Subsection (b), a health maintenance
4 organization that is an affiliate is considered to be a separate
5 health benefit plan issuer for purposes of this chapter. (V.T.I.C.
6 Art. 26.03.)

7 Sec. 1501.008. LATE ENROLLEES. (a) For purposes of this
8 chapter, an employee or dependent eligible for enrollment in a
9 small or large employer's health benefit plan is a late enrollee if
10 the individual requests enrollment after the expiration of:

11 (1) the initial enrollment period established under
12 the terms of the first plan for which the individual was eligible
13 through the small or large employer; or

14 (2) an open enrollment period under Section
15 1501.156(a) or 1501.606(a).

16 (b) An employee or dependent eligible for enrollment is not
17 a late enrollee if the individual:

18 (1) was covered under another health benefit plan or
19 self-funded employer health benefit plan at the time the individual
20 was eligible to enroll;

21 (2) declined enrollment in writing, at the time of the
22 initial eligibility for enrollment, stating that coverage under
23 another health benefit plan or self-funded employer health benefit
24 plan was the reason for declining enrollment;

25 (3) has lost coverage under the other health benefit
26 plan or self-funded employer health benefit plan as a result of:

27 (A) the termination of employment;

1 (B) a reduction in the number of hours of
2 employment;

3 (C) the termination of the other plan's coverage;

4 (D) the termination of contributions toward the
5 premium made by the employer; or

6 (E) the death of a spouse or divorce; and

7 (4) requests enrollment not later than the 31st day
8 after the date coverage under the other health benefit plan or
9 self-funded employer health benefit plan terminates.

10 (c) An employee or dependent eligible for enrollment is also
11 not a late enrollee if the individual is:

12 (1) employed by an employer that offers multiple
13 health benefit plans and the individual elects a different health
14 benefit plan during an open enrollment period;

15 (2) a spouse for whom a court has ordered coverage
16 under a covered employee's plan and the request for enrollment of
17 the spouse is made not later than the 31st day after the date the
18 court order is issued;

19 (3) a child for whom a court has ordered coverage under
20 a covered employee's plan and the request for enrollment is made not
21 later than the 31st day after the date the employer receives the
22 court order; or

23 (4) a child of a covered employee who has lost coverage
24 under Title XIX of the Social Security Act (42 U.S.C. Section 1396
25 et seq.), other than coverage consisting solely of benefits under
26 Section 1928 of that Act (42 U.S.C. Section 1396s), or under Chapter
27 62, Health and Safety Code, and the request for enrollment is made

1 not later than the 31st day after the date on which the child loses
2 coverage. (V.T.I.C. Art. 26.02, Subdiv. (18).)

3 Sec. 1501.009. SCHOOL DISTRICT ELECTION. (a) An
4 independent school district may elect to participate as a small
5 employer without regard to the number of eligible employees in the
6 district. An independent school district that makes the election
7 is treated as a small employer under this chapter for all purposes.

8 (b) An independent school district that is participating in
9 the uniform group coverage program established under Article 3.50-7
10 may not participate in the small employer market under this section
11 for health insurance coverage and may not renew a health insurance
12 contract obtained in accordance with this section after the date on
13 which the program of coverages provided under Article 3.50-7 is
14 implemented. This subsection does not affect a contract for the
15 provision of optional coverages not included in a health benefit
16 plan under this chapter. (V.T.I.C. Art. 26.036.)

17 Sec. 1501.010. GENERAL RULES. The commissioner shall adopt
18 rules necessary to:

- 19 (1) implement this chapter; and
20 (2) meet the minimum requirements of federal law,
21 including regulations. (V.T.I.C. Art. 26.04.)

22 Sec. 1501.011. DETERMINATION OF EMPLOYER STATUS FOR CERTAIN
23 EMPLOYERS. (a) For an employer that did not exist throughout the
24 calendar year preceding the year in which the determination of
25 whether the employer is a small employer is made, the determination
26 is based on the average number of employees and eligible employees
27 the employer reasonably expects to employ on business days in the

1 calendar year in which the determination is made.

2 (b) For an employer that did not exist throughout the
3 calendar year preceding the year in which the determination of
4 whether the employer is a large employer is made, the determination
5 is based on the average number of eligible employees the employer
6 reasonably expects to employ on business days in the calendar year
7 in which the determination is made. (V.T.I.C. Art. 26.06, Subsec.
8 (b); Art. 26.81, Subsec. (b).)

9 [Sections 1501.012-1501.050 reserved for expansion]

10 SUBCHAPTER B. PURCHASING COOPERATIVES

11 Sec. 1501.051. DEFINITIONS. In this subchapter:

12 (1) "Board of directors" means the board of directors
13 elected by a private purchasing cooperative.

14 (2) "Board of trustees" means the board of trustees of
15 the Texas cooperative.

16 (3) "Cooperative" means a purchasing cooperative
17 established under this subchapter.

18 (4) "Texas cooperative" means the Texas Health
19 Benefits Purchasing Cooperative established under Section
20 1501.052. (V.T.I.C. Art. 26.11.)

21 Sec. 1501.052. TEXAS HEALTH BENEFITS PURCHASING
22 COOPERATIVE; BOARD OF TRUSTEES. (a) The Texas Health Benefits
23 Purchasing Cooperative is a nonprofit corporation established to
24 make health care coverage available to small and large employers
25 and their eligible employees and the eligible employees'
26 dependents.

27 (b) The Texas cooperative is administered by a board of

1 trustees of six members appointed by the governor with the advice
2 and consent of the senate. Three members must represent employers,
3 two members must represent employees, and one member must represent
4 the public.

5 (c) Members of the board of trustees serve staggered
6 six-year terms, with the terms of two members expiring February 1 of
7 each odd-numbered year.

8 (d) A member of the board of trustees may not be compensated
9 for serving on the board but is entitled to reimbursement for actual
10 expenses incurred in performing functions as a member of the board
11 as provided by the General Appropriations Act. (V.T.I.C. Art.
12 26.13, Subsecs. (a), (b), (c), (d).)

13 Sec. 1501.053. TEXAS HEALTH BENEFITS PURCHASING
14 COOPERATIVE: EXECUTIVE DIRECTOR AND OTHER EMPLOYEES. (a) The
15 board of trustees shall employ an executive director. The
16 executive director may hire other employees of the Texas
17 cooperative as necessary.

18 (b) Salaries for employees of the Texas cooperative and
19 related costs may be paid from administrative fees collected from
20 employers and participating health benefit plan issuers or other
21 sources of funding arranged by the Texas cooperative. (V.T.I.C.
22 Art. 26.13, Subsecs. (e), (g).)

23 Sec. 1501.054. REGIONAL SUBDIVISIONS OF TEXAS HEALTH
24 BENEFITS PURCHASING COOPERATIVE. The board of trustees may:

25 (1) develop regional subdivisions of the Texas
26 cooperative; and

27 (2) authorize each subdivision to separately exercise

1 the powers and duties of a cooperative. (V.T.I.C. Art. 26.13,
2 Subsec. (f).)

3 Sec. 1501.055. APPLICABILITY OF PUBLIC INFORMATION LAW TO
4 TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. The Texas
5 cooperative is subject to the public information law, Chapter 552,
6 Government Code. (V.T.I.C. Art. 26.12, Subsec. (b).)

7 Sec. 1501.056. PRIVATE PURCHASING COOPERATIVES. (a) Two
8 or more small or large employers may form a private cooperative to
9 purchase small or large employer health benefit plans. The
10 cooperative must be organized as a nonprofit corporation and has
11 the rights and duties provided by the Texas Non-Profit Corporation
12 Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes).

13 (b) On receipt of a certificate of incorporation or
14 certificate of authority from the secretary of state, the
15 cooperative shall file written notice of the receipt of the
16 certificate and a copy of the cooperative's organizational
17 documents with the commissioner.

18 (c) Annually, the board of directors shall file with the
19 commissioner a statement of all amounts collected and expenses
20 incurred for each of the preceding three years. (V.T.I.C. Art.
21 26.14, Subsecs. (a), (b), (c).)

22 Sec. 1501.057. IMMUNITY. (a) The Texas cooperative or a
23 member of the board of trustees, the executive director, or an
24 employee or agent of the Texas cooperative is not liable for:

25 (1) an act performed in good faith in the execution of
26 duties in connection with the cooperative; or

27 (2) an independent action of a small employer health

1 benefit plan issuer or a person who provides health care services
2 under a health benefit plan.

3 (b) A private purchasing cooperative or a member of the
4 board of directors, the executive director, or an employee or agent
5 of the cooperative is not liable for:

6 (1) an act performed in good faith in the execution of
7 duties in connection with the cooperative; or

8 (2) an independent action of a small or large employer
9 health benefit plan issuer or a person who provides health care
10 services under a health benefit plan. (V.T.I.C. Art. 26.13,
11 Subsec. (h); Art. 26.14, Subsec. (d).)

12 Sec. 1501.058. POWERS AND DUTIES OF COOPERATIVES. (a) A
13 cooperative shall:

14 (1) arrange for small or large employer health benefit
15 plan coverage for small or large employer groups that participate
16 in the cooperative by contracting with small or large employer
17 health benefit plan issuers that meet the requirements established
18 by Section 1501.061;

19 (2) collect premiums to cover the cost of:

20 (A) small or large employer health benefit plan
21 coverage purchased through the cooperative; and

22 (B) the cooperative's administrative expenses;

23 (3) establish administrative and accounting
24 procedures for the operation of the cooperative;

25 (4) establish procedures under which an applicant for
26 or participant in coverage issued through the cooperative may have
27 a grievance reviewed by an impartial person;

1 (5) contract with small or large employer health
2 benefit plan issuers to provide services to small or large
3 employers covered through the cooperative; and

4 (6) develop and implement a plan to maintain public
5 awareness of the cooperative and publicize the eligibility
6 requirements for, and the procedures for enrollment in, coverage
7 through the cooperative.

8 (b) A cooperative may:

9 (1) contract with agents to market coverage issued
10 through the cooperative;

11 (2) contract with a small or large employer health
12 benefit plan issuer or third-party administrator to provide
13 administrative services to the cooperative;

14 (3) negotiate the premiums paid by its members; and

15 (4) offer other ancillary products and services to its
16 members that are customarily offered in conjunction with health
17 benefit plans.

18 (c) A cooperative shall comply with:

19 (1) federal laws applicable to cooperatives and health
20 benefit plans issued through cooperatives, to the extent required
21 by state law or rules adopted by the commissioner; and

22 (2) state laws applicable to cooperatives and health
23 benefit plans issued through cooperatives. (V.T.I.C. Art. 26.15,
24 Subsecs. (a), (d).)

25 Sec. 1501.059. SELF-INSURED OR SELF-FUNDED PLAN
26 PROHIBITED. A cooperative may not self-insure or self-fund any
27 health benefit plan or portion of a plan. (V.T.I.C. Art. 26.15,

Subsec. (c).)

Sec. 1501.060. SCOPE OF GROUP COVERAGE. Subchapter B, Chapter 1251, does not limit the type of group that may be covered by a group health benefit plan issued through a cooperative. (V.T.I.C. Art. 26.12, Subsec. (a).)

Sec. 1501.061. REQUIREMENTS APPLICABLE TO HEALTH BENEFIT PLAN ISSUERS WITH WHICH COOPERATIVE MAY CONTRACT. A cooperative may contract only with a small or large employer health benefit plan issuer that desires to offer coverage through the cooperative and that demonstrates that the issuer:

(1) is in good standing with the department;

(2) has the capacity to administer health benefit plans;

(3) is able to monitor and evaluate the quality and cost-effectiveness of care and applicable procedures;

(4) is able to conduct utilization management and establish applicable procedures and policies;

(5) is able to ensure that enrollees have adequate access to health care providers, including adequate numbers and types of providers;

(6) has a satisfactory grievance procedure and is able to respond to enrollees' calls, questions, and complaints; and

(7) has financial capacity, either through satisfying financial solvency standards, as applied by the commissioner, or through appropriate reinsurance or other risk-sharing mechanisms. (V.T.I.C. Art. 26.15, Subsec. (b).)

Sec. 1501.062. COOPERATIVE NOT INSURER; AGENTS AND

1 ADMINISTRATORS. (a) A cooperative is not an insurer and the
2 employees of the cooperative are not required to be licensed under
3 Title 13.

4 (b) An agent or third-party administrator used and
5 compensated by a cooperative must be licensed as required by Title
6 13.

7 (c) An agent used and compensated by a cooperative may
8 market the products and services sponsored by the cooperative
9 without being appointed by each small employer health benefit plan
10 issuer participating in the cooperative. The agent may not market
11 any other product or service of a participating issuer that is not
12 sponsored by the cooperative unless the agent has been appointed by
13 that issuer. (V.T.I.C. Art. 26.16, Subsecs. (a), (c), (d).)

14 Sec. 1501.063. COOPERATIVE AS EMPLOYER. A cooperative is
15 considered an employer solely for the purposes of benefit elections
16 under this code. (V.T.I.C. Art. 26.16, Subsec. (b).)

17 Sec. 1501.064. CERTAIN USE OF APPROPRIATED MONEY
18 PROHIBITED. The Texas cooperative may not use money appropriated
19 by the state to pay or otherwise subsidize any portion of the
20 premium for a small employer covered through the cooperative.
21 (V.T.I.C. Art. 26.13, Subsec. (i).)

22 [Sections 1501.065-1501.100 reserved for expansion]

23 SUBCHAPTER C. PROVISION OF COVERAGE

24 Sec. 1501.101. GEOGRAPHIC SERVICE AREAS. (a) A small or
25 large employer health benefit plan issuer must file each of the
26 issuer's geographic service areas with the commissioner. The
27 commissioner may disapprove the use of a geographic service area by

1 a small or large employer health benefit plan issuer.

2 (b) A small employer health benefit plan issuer that refuses
3 to issue a small employer health benefit plan in a geographic
4 service area may not offer a health benefit plan to a small employer
5 in the applicable service area before the fifth anniversary of the
6 date of the refusal.

7 (c) A small or large employer health benefit plan issuer is
8 not required to offer or issue a small or large employer health
9 benefit plan to:

10 (1) a small or large employer that is not located
11 within a geographic service area of the issuer;

12 (2) an employee of a small or large employer who
13 neither resides nor works in the geographic service area of the
14 issuer; or

15 (3) a small or large employer located within a
16 geographic service area of the issuer with respect to which area the
17 issuer demonstrates to the commissioner's satisfaction that the
18 issuer:

19 (A) reasonably anticipates that it will not have
20 the capacity to deliver services adequately because of obligations
21 to existing covered individuals; and

22 (B) is acting uniformly without regard to the
23 claims experience of the employer or any health status related
24 factor of employees, employees' dependents, or new employees or
25 dependents who may become eligible for the coverage.

26 (d) A small or large employer health benefit plan issuer
27 that is unable to offer coverage in a geographic service area in

1 accordance with a determination made by the commissioner under
2 Subsection (c)(3) may not offer a small or large employer benefit
3 plan, as applicable, in that service area before the 180th day after
4 the later of:

5 (1) the date the issuer refuses to offer coverage; or

6 (2) the date the issuer demonstrates to the
7 satisfaction of the commissioner that it has regained the capacity
8 to deliver services to small or large employers in the geographic
9 service area.

10 (e) If the commissioner determines that requiring the
11 acceptance of small or large employers under this chapter would
12 place a small or large employer health benefit plan issuer in a
13 financially impaired condition and that the issuer is acting
14 uniformly without regard to the claims experience of the small or
15 large employer or any health status related factors of eligible
16 employees, eligible employees' dependents, or new employees or
17 dependents who may become eligible for the coverage, the issuer may
18 not offer coverage to small or large employers until the later of:

19 (1) the 180th day after the date the commissioner
20 makes the determination; or

21 (2) the date the commissioner determines that
22 accepting small or large employers would not place the issuer in a
23 financially impaired condition. (V.T.I.C. Arts. 26.22, 26.85.)

24 Sec. 1501.102. PREEXISTING CONDITION PROVISION. (a) In
25 this section, "creditable coverage" has the meaning assigned by
26 Section 1205.004 and includes coverage provided under:

27 (1) a political subdivision health benefits risk pool;

1 and

2 (2) a short-term limited duration coverage plan.

3 (b) A preexisting condition provision in a small or large
4 employer health benefit plan may apply only to coverage for a
5 disease or condition for which medical advice, diagnosis, care, or
6 treatment was recommended or received during the six months before
7 the earlier of:

8 (1) the effective date of coverage; or

9 (2) the first day of the waiting period.

10 (c) A preexisting condition provision in a small or large
11 employer health benefit plan may not apply to expenses incurred on
12 or after the first anniversary of the initial effective date of
13 coverage of the enrollee, including a late enrollee.

14 (d) A preexisting condition provision in a small or large
15 employer health benefit plan may not apply to an individual who was
16 continuously covered for an aggregate period of 12 months under
17 creditable coverage that was in effect until a date not more than 63
18 days before the effective date of coverage under the plan,
19 excluding any waiting period.

20 (e) In determining whether a preexisting condition
21 provision applies to an individual covered by a small or large
22 employer health benefit plan, the plan issuer shall credit the time
23 the individual was covered under previous creditable coverage if
24 the previous coverage was in effect at any time during the 12 months
25 preceding the effective date of coverage under the plan. If the
26 previous coverage was issued under a health benefit plan, any
27 waiting period that applied before that coverage became effective

1 must also be credited against the preexisting condition provision
2 period. (V.T.I.C. Art. 26.02, Subdiv. (7); Art. 26.035; Art.
3 26.49, Subsecs. (a), (b), (e), (f); Art. 26.90, Subsecs. (a), (b),
4 (e), (f).)

5 Sec. 1501.103. TREATMENT OF CERTAIN CONDITIONS AS
6 PREEXISTING PROHIBITED. (a) A small or large employer health
7 benefit plan issuer may not treat genetic information as a
8 preexisting condition described by Section 1501.102(b) in the
9 absence of a diagnosis of the condition related to the information.

10 (b) A small or large employer health benefit plan issuer may
11 not treat pregnancy as a preexisting condition described by Section
12 1501.102(b). (V.T.I.C. Art. 26.49, Subsecs. (c), (d); Art. 26.90,
13 Subsecs. (c), (d).)

14 Sec. 1501.104. AFFILIATION PERIOD. (a) In this section,
15 "affiliation period" means a period that, under a small or large
16 employer health benefit plan offered by a health maintenance
17 organization, must expire before the coverage becomes effective.

18 (b) A health maintenance organization may impose an
19 affiliation period if the period is applied uniformly without
20 regard to any health status related factor. The affiliation period
21 may not exceed:

22 (1) two months for an enrollee, other than a late
23 enrollee; or

24 (2) 90 days for a late enrollee.

25 (c) An affiliation period under a small or large employer
26 health benefit plan must run concurrently with any applicable
27 waiting period under the plan. A health maintenance organization

1 must credit an affiliation period against any preexisting condition
2 provision period.

3 (d) During an affiliation period, a health maintenance
4 organization:

5 (1) is not required to provide health care services or
6 benefits to the participant or beneficiary; and

7 (2) may not charge a premium to the participant or
8 beneficiary.

9 (e) A health maintenance organization may use an
10 alternative method approved by the commissioner to address adverse
11 selection. (V.T.I.C. Art. 26.02, Subdiv. (1); Art. 26.49, Subsec.
12 (g); Art. 26.90, Subsec. (g).)

13 Sec. 1501.105. WAITING PERIOD PERMITTED. Sections
14 1501.102-1501.104 do not preclude application of a waiting period
15 that applies to all new enrollees under a small or large employer
16 health benefit plan. (V.T.I.C. Art. 26.49, Subsec. (h); Art.
17 26.90, Subsec. (h).)

18 Sec. 1501.106. CERTAIN LIMITATIONS OR EXCLUSIONS OF
19 COVERAGE PROHIBITED. (a) A small or large employer health benefit
20 plan may not limit or exclude, by use of a rider or amendment
21 applicable to a specific individual, coverage by type of illness,
22 treatment, medical condition, or accident.

23 (b) This section does not preclude a small or large employer
24 health benefit plan from limiting or excluding coverage for a
25 preexisting condition in accordance with Section 1501.102.
26 (V.T.I.C. Art. 26.21, Subsec. (m); Art. 26.83, Subsec. (m).)

27 Sec. 1501.107. DISCOUNTS, REBATES, AND REDUCTIONS. (a) A

1 small or large employer health benefit plan issuer may establish
2 premium discounts, rebates, or a reduction in otherwise applicable
3 copayments or deductibles in return for adherence to programs of
4 health promotion and disease prevention.

5 (b) A discount, rebate, or reduction established under this
6 section does not violate Section 541.056(a). (V.T.I.C. Art. 26.33,
7 Subsec. (e); Art. 26.89, Subsec. (b).)

8 Sec. 1501.108. RENEWABILITY OF COVERAGE; CANCELLATION. (a)
9 Except as provided by Section 1501.109, a small or large employer
10 health benefit plan issuer shall renew the small or large employer
11 health benefit plan for any covered small or large employer, as
12 applicable, at the employer's option, unless:

13 (1) a premium has not been paid as required by the
14 terms of the plan;

15 (2) the employer has committed fraud or has
16 intentionally misrepresented a material fact;

17 (3) the employer has not complied with the terms of the
18 plan;

19 (4) no enrollee in the plan resides or works in the
20 geographic service area of the small or large employer health
21 benefit plan issuer or in the area for which the issuer is
22 authorized to do business; or

23 (5) membership of the employer in an association
24 terminates, but only if coverage is terminated uniformly without
25 regard to a health status related factor of a covered individual.

26 (b) A small or large employer health benefit plan issuer may
27 refuse to renew the coverage of a covered employee or dependent for

1 fraud or intentional misrepresentation of a material fact by that
2 individual.

3 (c) A small or large employer health benefit plan issuer may
4 not cancel a small or large employer health benefit plan except for
5 a reason specified for refusal to renew under Subsection (a). A
6 small or large employer health benefit plan issuer may not cancel
7 the coverage of a covered employee or dependent except for a reason
8 specified for refusal to renew under Subsection (b). (V.T.I.C.
9 Arts. 26.23, 26.86.)

10 Sec. 1501.109. REFUSAL TO RENEW; DISCONTINUATION OF
11 COVERAGE. (a) A small or large employer health benefit plan issuer
12 may elect to refuse to renew all small or large employer health
13 benefit plans delivered or issued for delivery by the issuer in this
14 state or in a geographic service area approved under Section
15 1501.101. The issuer shall notify:

16 (1) the commissioner of the election not later than
17 the 180th day before the date coverage under the first plan
18 terminates under this subsection; and

19 (2) each affected covered small or large employer not
20 later than the 180th day before the date coverage terminates for
21 that employer.

22 (b) A small employer health benefit plan issuer that elects
23 under this section to refuse to renew all small employer health
24 benefit plans in this state or in an approved geographic service
25 area may not write a new small employer health benefit plan in this
26 state or in the geographic service area, as applicable, before the
27 fifth anniversary of the date notice is provided to the

1 commissioner under Subsection (a).

2 (c) A large employer health benefit plan issuer that elects
3 under this section to refuse to renew all large employer health
4 benefit plans in this state or in an approved geographic service
5 area may not write a new large employer health benefit plan in this
6 state or in the geographic service area, as applicable, before the
7 fifth anniversary of the date notice is provided to the
8 commissioner under Subsection (a).

9 (d) A small or large employer health benefit plan issuer may
10 elect to discontinue a particular type of small or large employer
11 coverage only if the issuer:

12 (1) before the 90th day preceding the date of the
13 discontinuation of the coverage:

14 (A) provides notice of the discontinuation to the
15 employer and the commissioner; and

16 (B) offers to each employer the option to
17 purchase other small or large employer coverage offered by the
18 issuer at the time of the discontinuation; and

19 (2) acts uniformly without regard to the claims
20 experience of the employer or any health status related factors of
21 eligible employees, eligible employees' dependents, or new
22 employees or dependents who may become eligible for the coverage.
23 (V.T.I.C. Arts. 26.24, 26.87.)

24 Sec. 1501.110. NOTICE TO COVERED PERSONS. (a) A small or
25 large employer health benefit plan issuer that cancels or refuses
26 to renew coverage under a small or large employer health benefit
27 plan under Section 1501.108 or 1501.109 shall, not later than the

1 30th day before the date termination of coverage is effective,
2 notify the small or large employer of the cancellation of or refusal
3 to renew coverage. The employer is responsible for notifying
4 enrollees in the plan of the cancellation of or refusal to renew
5 coverage.

6 (b) The notice provided to a small or large employer by a
7 small or large employer health benefit plan issuer under this
8 section is in addition to any other notice required by Section
9 1501.109. (V.T.I.C. Arts. 26.25, 26.88.)

10 Sec. 1501.111. WRITTEN STATEMENT OF DENIAL, CANCELLATION,
11 OR REFUSAL TO RENEW REQUIRED. Denial by a small or large employer
12 health benefit plan issuer of an application from a small or large
13 employer for coverage from the issuer or cancellation of or refusal
14 to renew coverage by a small or large employer health benefit plan
15 issuer must:

16 (1) be in writing; and

17 (2) state the reason or reasons for the denial,
18 cancellation, or refusal to renew. (V.T.I.C. Arts. 26.74, 26.94.)

19 [Sections 1501.112-1501.150 reserved for expansion]

20 SUBCHAPTER D. GUARANTEED ISSUE OF SMALL EMPLOYER HEALTH

21 BENEFIT PLANS; CONTINUATION OF COVERAGE

22 Sec. 1501.151. GUARANTEED ISSUE. (a) A small employer
23 health benefit plan issuer shall issue the small employer health
24 benefit plan chosen by the small employer to each small employer
25 that elects to be covered under the plan and agrees to satisfy the
26 other requirements of the plan.

27 (b) A small employer health benefit plan issuer shall

1 provide small employer health benefit plans without regard to
2 health status related factors.

3 (c) This chapter does not require a small employer to
4 purchase health coverage for the employer's employees. (V.T.I.C.
5 Art. 26.21, Subsecs. (a), (c) (part).)

6 Sec. 1501.152. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT
7 PROHIBITED. A small employer health benefit plan issuer may not
8 exclude an eligible employee or dependent, including a late
9 enrollee, who would otherwise be covered under a small employer
10 group. (V.T.I.C. Art. 26.21, Subsec. (1).)

11 Sec. 1501.153. EMPLOYER CONTRIBUTION. (a) This chapter
12 does not require a small employer to make an employer contribution
13 to the premium paid to a small employer health benefit plan issuer,
14 but the issuer may require an employer contribution in accordance
15 with the issuer's usual and customary practices applicable to the
16 issuer's employer group health benefit plans in this state. The
17 issuer shall apply the employer contribution level uniformly to
18 each small employer offered or issued coverage by the issuer in this
19 state.

20 (b) If two or more small employer health benefit plan
21 issuers participate in a purchasing cooperative established under
22 Section 1501.056, each participating issuer may use the employer
23 contribution requirement established by the cooperative for
24 policies marketed by the cooperative.

25 (c) A small employer that elects to make an employer
26 contribution to the premium paid to a small employer health benefit
27 plan issuer is not required to pay any amount with respect to an

1 employee who elects not to be covered.

2 (d) A small employer may elect to pay the premium for
3 additional coverage. (V.T.I.C. Art. 26.21, Subsecs. (b) (part),
4 (c) (part).)

5 Sec. 1501.154. MINIMUM PARTICIPATION REQUIREMENT. (a)
6 Except as provided by Section 1501.155, coverage is available under
7 a small employer health benefit plan if at least 75 percent of a
8 small employer's eligible employees elect to participate in the
9 plan.

10 (b) If a small employer offers multiple health benefit
11 plans, the collective participation in those plans must be at
12 least:

13 (1) 75 percent of the employer's eligible employees;
14 or

15 (2) if applicable, the lower participation level
16 offered by the small employer health benefit plan issuer under
17 Section 1501.155.

18 (c) A small employer health benefit plan issuer may elect
19 not to offer a health benefit plan to a small employer that offers
20 multiple health benefit plans if:

21 (1) the plans are provided by more than one issuer;
22 (2) the issuer would have less than 75 percent of the
23 employer's eligible employees enrolled in the issuer's plan; and
24 (3) the issuer's plan is not provided through a
25 purchasing cooperative. (V.T.I.C. Art. 26.21, Subsecs. (b) (part),
26 (c) (part).)

27 Sec. 1501.155. EXCEPTION TO MINIMUM PARTICIPATION

1 REQUIREMENT. (a) A small employer health benefit plan issuer may
2 offer a small employer health benefit plan to a small employer with
3 a participation level of less than 75 percent of the employer's
4 eligible employees if the issuer permits the same qualifying
5 participation level for each small employer health benefit plan
6 offered by the issuer in this state.

7 (b) A small employer health benefit plan issuer may offer a
8 small employer health benefit plan to a small employer even if the
9 employer's participation level is less than the issuer's qualifying
10 participation level established in accordance with Subsection (a)
11 if:

12 (1) the employer obtains a written waiver from each
13 eligible employee who declines coverage under a health benefit plan
14 offered to the employer stating that the employee was not induced or
15 pressured to decline coverage because of the employee's risk
16 characteristics; and

17 (2) the issuer accepts or rejects the entire group of
18 eligible employees who choose to participate and excludes only
19 those employees who have declined coverage.

20 (c) A small employer health benefit plan issuer may
21 underwrite the group of eligible employees who do not decline
22 coverage under Subsection (b).

23 (d) A small employer health benefit plan issuer may not
24 provide coverage to a small employer or the employer's employees
25 under Subsection (b) if the issuer or an agent for the issuer knows
26 that the employer has induced or pressured an eligible employee or a
27 dependent of the employee to decline coverage because of the

1 individual's risk characteristics.

2 (e) A small employer health benefit plan issuer, a small
3 employer, or an agent may not use the exception provided by
4 Subsection (b) to circumvent the requirements of this chapter.
5 (V.T.I.C. Art. 26.21, Subsecs. (d), (e), (f).)

6 Sec. 1501.156. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a)
7 The initial enrollment period under a small employer health benefit
8 plan for employees and dependents must be at least 31 days, with a
9 31-day open enrollment period provided annually.

10 (b) A small employer may establish a waiting period not to
11 exceed 90 days from the first day of employment.

12 (c) A small employer health benefit plan issuer may not deny
13 coverage to a new employee of a covered small employer or the
14 employee's dependents if the issuer receives an application for
15 coverage not later than the 31st day after the date employment
16 begins or on completion of a waiting period established under
17 Subsection (b).

18 (d) A small employer health benefit plan issuer may deny
19 coverage to a late enrollee until the next annual open enrollment
20 period and may subject the enrollee to a one-year preexisting
21 condition provision as described by Section 1501.102. The period
22 during which the preexisting condition provision applies may not
23 exceed 18 months from the date of the initial application.
24 (V.T.I.C. Art. 26.21, Subsecs. (h), (i), (j), (k).)

25 Sec. 1501.157. COVERAGE FOR NEWBORN CHILDREN. (a) A small
26 employer health benefit plan may not limit or exclude initial
27 coverage of a newborn child of a covered employee.

1 (b) Coverage of a newborn child of a covered employee under
2 this section ends on the 32nd day after the date of the child's
3 birth unless, not later than the 31st day after the date of birth,
4 the small employer health benefit plan issuer receives:

5 (1) notice of the birth; and

6 (2) any required additional premium. (V.T.I.C. Art.
7 26.21, Subsec. (n).)

8 Sec. 1501.158. COVERAGE FOR ADOPTED CHILDREN. (a) A small
9 employer health benefit plan may not limit or exclude initial
10 coverage of an adopted child of an insured. A child is considered
11 to be the child of an insured if the insured is a party to a suit in
12 which the insured seeks to adopt the child.

13 (b) An adopted child of an insured may be enrolled, at the
14 insured's option, not later than the 31st day after:

15 (1) the date the insured becomes a party to a suit in
16 which the insured seeks to adopt the child; or

17 (2) the date the adoption becomes final.

18 (c) Coverage of an adopted child of an insured under this
19 section ends unless the small employer health benefit plan issuer
20 receives notice of the adoption and any required additional premium
21 not later than the 31st day after:

22 (1) the date the insured becomes a party to a suit in
23 which the insured seeks to adopt the child; or

24 (2) the date the adoption becomes final. (V.T.I.C.
25 Art. 26.21A.)

26 Sec. 1501.159. CONTINUATION OF COVERAGE FOR CERTAIN
27 DEPENDENTS. An employee's dependent may choose to continue

coverage under a small employer health benefit plan if:

(1) the dependent:

(A) is under one year of age; or

(B) has been covered by the small employer under a plan for at least one year;

(2) the dependent loses eligibility for coverage because of the death, divorce, or retirement of the employee, as provided by Subchapter G, Chapter 1251; and

(3) the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272) does not require continuation or conversion coverage for dependents of an employee. (V.T.I.C. Art. 26.21, Subsec. (o).)

[Sections 1501.160-1501.200 reserved for expansion]

SUBCHAPTER E. UNDERWRITING AND RATING OF

SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec. 1501.201. DEFINITIONS. In this subchapter:

(1) "Base premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by a small employer health benefit plan issuer to small employers with similar case characteristics for small employer health benefit plans that provide the same or similar coverage.

(2) "Case characteristics" means, with respect to a small employer, the geographic area in which the employer's employees reside, the age and gender of the individual employees and their dependents, the number of employees and dependents, the

1 appropriate industry classification as determined by the small
2 employer health benefit plan issuer, and other objective criteria
3 established by the issuer that are considered by the issuer in
4 setting premium rates for the employer. The term does not include:

5 (A) health status related factors;

6 (B) duration of coverage since the date of
7 issuance of a health benefit plan; or

8 (C) whether a covered individual is or may become
9 pregnant.

10 (3) "Class of business" means all small employers or a
11 separate grouping of small employers established under this
12 subchapter.

13 (4) "Index rate" means, for each class of business and
14 for a specific rating period for small employers with similar case
15 characteristics, the arithmetic average of the applicable base
16 premium rate and corresponding highest premium rate.

17 (5) "New business premium rate" means, for each class
18 of business and for a specific rating period, the lowest premium
19 rate that is charged or offered or that could be charged or offered
20 by a small employer health benefit plan issuer to small employers
21 with similar case characteristics for newly issued small employer
22 health benefit plans that provide the same or similar coverage.

23 (6) "Rating period" means a calendar period during
24 which premium rates established by a small employer health benefit
25 plan issuer are assumed to be in effect. (V.T.I.C. Art. 26.02,
26 Subdivs. (3), (5), (6), (14), (19), (26).)

27 Sec. 1501.202. ESTABLISHMENT OF CLASSES OF BUSINESS. (a)

1 Except as otherwise provided by this subchapter, a small employer
2 health benefit plan issuer may not establish a separate class or
3 classes of business for small employers.

4 (b) A small employer health benefit plan issuer may
5 establish a separate class of business only to reflect substantial
6 differences in expected claims experience or administrative costs
7 related to the following reasons:

8 (1) the issuer uses more than one type of system to
9 market and sell small employer health benefit plans to small
10 employers;

11 (2) the issuer has acquired a class of business from
12 another small employer health benefit plan issuer; or

13 (3) the issuer provides coverage to one or more
14 employer-based association groups.

15 (c) Except as provided by Subsection (e), a small employer
16 health benefit plan issuer may not establish more than nine
17 separate classes of business under this section.

18 (d) The commissioner may adopt rules to provide for a
19 transition period to permit a small employer health benefit plan
20 issuer to comply with Subsection (c) after acquiring an additional
21 class of business from another small employer health benefit plan
22 issuer.

23 (e) On application to the commissioner, the commissioner
24 may approve the establishment of additional classes of business if
25 the commissioner finds that the establishment of additional classes
26 would enhance the efficiency and fairness of the health coverage
27 market for small employers. (V.T.I.C. Art. 26.21, Subsec. (g);

1 Art. 26.31, Subsecs. (a), (b), (c), (d).)

2 Sec. 1501.203. ESTABLISHMENT OF CLASSES OF BUSINESS ON
3 CERTAIN BASES PROHIBITED. (a) A small employer health benefit plan
4 issuer may not establish a separate class of business based on:

5 (1) participation requirements; or

6 (2) whether the coverage provided to a small employer
7 group is provided on a guaranteed issue basis or is subject to
8 underwriting or proof of insurability.

9 (b) A small employer health benefit plan issuer may not
10 directly or indirectly use as a criterion for establishing a
11 separate class of business:

12 (1) the number of employees and dependents of a small
13 employer; or

14 (2) except as provided by Section 1501.202(b)(3), the
15 trade or occupation of the employees of a small employer or the
16 industry or type of business of the small employer. (V.T.I.C. Art.
17 26.31, Subsecs. (e), (f), (g).)

18 Sec. 1501.204. INDEX RATES. Under a small employer health
19 benefit plan:

20 (1) the index rate for a class of business may not
21 exceed the index rate for any other class of business by more than
22 20 percent; and

23 (2) premium rates charged during a rating period to
24 small employers in a class of business with similar case
25 characteristics for the same or similar coverage, or premium rates
26 that could be charged to those employers under the rating system for
27 that class of business, may not vary from the index rate by more

1 than 25 percent. (V.T.I.C. Art. 26.32, Subsecs. (a), (b), (c).)

2 Sec. 1501.205. PREMIUM RATES: ESTABLISHMENT. (a) In this
3 section:

4 (1) "Risk characteristic" means:

5 (A) a health status related factor;

6 (B) the duration of coverage; or

7 (C) any characteristic similar to a
8 characteristic described by Paragraph (A) or (B) that is related to
9 the health status or experience of a small employer group or of any
10 member of a small employer group.

11 (2) "Risk load" means the percentage above the
12 applicable base premium rate a small employer health benefit plan
13 issuer charges to a small employer to reflect the risk
14 characteristics associated with that particular small employer
15 group.

16 (b) Small employer health benefit plan issuers shall
17 develop premium rates for each small employer group in a two-step
18 process. In the first step, the small employer health benefit plan
19 issuer shall develop a base premium rate for each small employer
20 group without regard to any risk characteristic of the group. In
21 the second step, the small employer health benefit plan issuer may
22 adjust the resulting base premium rate by the risk load of the
23 group, subject to this subchapter, to reflect the risk
24 characteristics of the group.

25 (c) The risk load assessed to a particular group shall
26 reflect the risk characteristics of the particular group.
27 (V.T.I.C. Art. 26.02, Subdivs. (28), (29), as amended Acts 77th

1 Leg., R.S., Ch. 823; Art. 26.32, Subsecs. (d), (e).)

2 Sec. 1501.206. PREMIUM RATES: ADJUSTMENTS. (a) The
3 percentage increase in the premium rate charged to a small employer
4 for a new rating period may not exceed the sum of:

5 (1) the percentage change in the new business premium
6 rate, measured from the first day of the preceding rating period to
7 the first day of the new rating period;

8 (2) any adjustment, not to exceed 15 percent annually
9 and adjusted pro rata for a rating period of less than one year, due
10 to the claims experience, health status, or duration of coverage of
11 the employees or dependents of employees of the small employer, as
12 determined under the small employer health benefit plan issuer's
13 rate manual for the class of business; and

14 (3) any adjustment due to change in coverage or change
15 in the case characteristics of the small employer, as determined
16 under the issuer's rate manual for the class of business.

17 (b) An adjustment in the premium rate for claims experience,
18 health status, or duration of coverage:

19 (1) may not be charged to individual employees or
20 dependents; and

21 (2) must be applied uniformly to the rates charged for
22 all employees and dependents of employees of the small employer.
23 (V.T.I.C. Art. 26.33, Subsecs. (a), (b).)

24 Sec. 1501.207. PREMIUM RATE ADJUSTMENT IN CLOSED PLAN. For
25 a closed health benefit plan under which a small employer health
26 benefit plan issuer is no longer enrolling new small employers, the
27 issuer shall use the percentage change in the base premium rate to

1 adjust premium rates under Section 1501.206(a)(1). The portion of
2 change in premium rates computed under that subdivision may not
3 exceed, on a percentage basis, the change in the new business
4 premium rate for the most similar health benefit plan under which
5 the issuer is enrolling new small employers. (V.T.I.C. Art.
6 26.35.)

7 Sec. 1501.208. PREMIUM RATES: INDUSTRY CLASSIFICATION. A
8 small employer health benefit plan issuer may use the industry
9 classification to which a small employer belongs as a case
10 characteristic in establishing the premium rate, but the highest
11 rate factor associated with any industry classification may not
12 exceed by more than 15 percent the lowest rate factor associated
13 with any industry classification. (V.T.I.C. Art. 26.33, Subsec.
14 (c).)

15 Sec. 1501.209. PREMIUM RATES: NUMBER OF EMPLOYEES. A small
16 employer health benefit plan issuer may use the number of employees
17 and dependents of a small employer as a case characteristic in
18 establishing premium rates for the group. The highest rate factor
19 associated with a classification based on the number of employees
20 and dependents of a small employer may not exceed by more than 20
21 percent the lowest rate factor associated with a classification
22 based on the number of employees and dependents of a small employer.
23 (V.T.I.C. Art. 26.33, Subsec. (d).)

24 Sec. 1501.210. PREMIUM RATES: NONDISCRIMINATION. (a) A
25 small employer health benefit plan issuer shall apply rating
26 factors, including case characteristics, consistently with respect
27 to all small employers in a class of business. Rating factors must

1 produce premium rates for identical groups that:

2 (1) differ only by the amounts attributable to health
3 benefit plan design; and

4 (2) do not reflect differences because of the nature
5 of the groups assumed to select particular health benefit plans.

6 (b) A small employer health benefit plan issuer shall treat
7 each health benefit plan issued or renewed in the same calendar
8 month as having the same rating period.

9 (c) Without the prior approval of the commissioner, a small
10 employer health benefit plan issuer may not use case
11 characteristics other than:

12 (1) the geographic area in which the small employer's
13 employees reside;

14 (2) the age and gender of the individual employees and
15 their dependents;

16 (3) the number of employees and dependents; and

17 (4) the appropriate industry classification.

18 (d) Premium rates for a small employer health benefit plan
19 must comply with the requirements of this chapter, notwithstanding
20 any assessment paid or payable by a small employer health benefit
21 plan issuer.

22 (e) A small employer health benefit plan issuer may not
23 transfer a small employer involuntarily into or out of a class of
24 business. The issuer may not offer to transfer a small employer
25 into or out of a class of business unless the offer is made to
26 transfer all other small employers in the employer's class of
27 business without regard to case characteristics, claims

1 experience, health status, or duration of coverage since the
2 issuance of the health benefit plan. (V.T.I.C. Art. 26.36,
3 Subsecs. (a), (b), (c), (d), (f).)

4 Sec. 1501.211. RULES CONCERNING PREMIUM RATES. Rules
5 adopted under Section 1501.010 may ensure that:

6 (1) rating practices used by small employer health
7 benefit plan issuers are consistent with the purposes of this
8 chapter; and

9 (2) differences in premium rates charged for each
10 small employer health benefit plan are reasonable and reflect
11 objective differences in plan design. (V.T.I.C. Art. 26.36,
12 Subsec. (e).)

13 Sec. 1501.212. RESTRICTED PROVIDER NETWORK. (a) A small
14 employer health benefit plan may use a restricted provider network
15 to provide benefits under the plan.

16 (b) A small employer health benefit plan that uses a
17 restricted provider network does not provide similar coverage to a
18 plan that does not use a restricted provider network if the use of
19 the network results in reduced premium rates charged to the small
20 employer or substantial differences in claim costs. (V.T.I.C. Art.
21 26.37.)

22 Sec. 1501.213. PREMIUM RATES: HEALTH MAINTENANCE
23 ORGANIZATION HEALTH BENEFIT PLAN. (a) The premium rates for a
24 state-approved health benefit plan offered by a health maintenance
25 organization under Section 1501.255 must be established in
26 accordance with formulas or schedules of charges filed with the
27 department.

1 (b) A health maintenance organization that participates in
2 a purchasing cooperative that provides employees of small employers
3 a choice of health benefit plans may use rating methods in
4 accordance with this subchapter that are used by other small
5 employer health benefit plan issuers participating in the same
6 cooperative, including rating by age and gender, if the health
7 maintenance organization has established:

8 (1) a separate class of business, as provided by
9 Section 1501.202; and

10 (2) a separate line of business, as provided under
11 Section 1501.255(b) and Title XIII, Public Health Service Act (42
12 U.S.C. Section 300e et seq.). (V.T.I.C. Art. 26.38.)

13 Sec. 1501.214. ENFORCEMENT. If the commissioner determines
14 that a small employer health benefit plan issuer subject to this
15 chapter exceeds the applicable premium rate established under this
16 subchapter, the commissioner may order restitution and assess
17 penalties as provided by Chapter 82. (V.T.I.C. Art. 26.39.)

18 Sec. 1501.215. REPORTING REQUIREMENTS. (a) Annually, each
19 small employer health benefit plan issuer that offers a small
20 employer health benefit plan shall file with the commissioner an
21 actuarial certification stating that the issuer's underwriting and
22 rating methods:

- 23 (1) comply with accepted actuarial practices;
24 (2) are uniformly applied to each small employer
25 health benefit plan covering a small employer; and
26 (3) comply with this subchapter.

27 (b) Each small employer health benefit plan issuer shall

1 maintain at its principal place of business a complete and detailed
2 description of its rating practices and renewal underwriting
3 practices, including information and documentation that
4 demonstrate that its rating methods and practices are based on
5 commonly accepted actuarial assumptions and are in accordance with
6 sound actuarial principles.

7 (c) A small employer health benefit plan issuer shall make
8 the information and documentation described in Subsection (b)
9 available to the commissioner on request. Unless the information
10 or documentation relates to a violation of this chapter, the
11 information or documentation is considered proprietary and trade
12 secret information and is not subject to disclosure by the
13 commissioner to a person outside the department except as agreed to
14 by the issuer or as ordered by a court. (V.T.I.C. Art. 26.41.)

15 [Sections 1501.216-1501.250 reserved for expansion]

16 SUBCHAPTER F. COVERAGE UNDER SMALL EMPLOYER HEALTH

17 BENEFIT PLANS

18 Sec. 1501.251. EXCEPTION FROM CERTAIN MANDATED BENEFIT
19 REQUIREMENTS. Except as expressly provided by this chapter, a
20 small employer health benefit plan is not subject to a law that
21 requires coverage or the offer of coverage of a health care service
22 or benefit. (V.T.I.C. Art. 26.06, Subsec. (d).)

23 Sec. 1501.252. HEALTH BENEFIT PLANS. (a) A small employer
24 health benefit plan issuer shall offer the following two health
25 benefit plans as adopted by the commissioner:

26 (1) the catastrophic care health benefit plan; and

27 (2) the basic coverage health benefit plan.

1 (b) A small employer health benefit plan issuer may offer to
2 a small employer additional benefit riders to either of the health
3 benefit plans required by Subsection (a).

4 (c) Subject to this chapter, a small employer health benefit
5 plan issuer may also offer to a small employer any other health
6 benefit plan authorized under this code. Section 1501.251 does not
7 apply to a health benefit plan offered to a small employer under
8 this subsection. (V.T.I.C. Art. 26.42.)

9 Sec. 1501.253. COVERAGE REQUIREMENTS. (a) The
10 commissioner by rule shall establish coverage requirements for the
11 catastrophic care health benefit plan and the basic coverage health
12 benefit plan.

13 (b) Coverage under the catastrophic care health benefit
14 plan must be designed to provide necessary coverage in the event of
15 catastrophic illness or injury. The commissioner shall establish
16 deductibles and coinsurance requirements at levels that permit
17 options for a covered individual to obtain affordable catastrophic
18 coverage.

19 (c) Coverage under the basic coverage health benefit plan
20 must be designed to provide basic hospital, medical, and surgical
21 coverage. Benefits under the plan are limited to basic care
22 requirements for illness and injury.

23 (d) The benefits provisions of the catastrophic care and
24 basic coverage health benefit plan policies must include:

- 25 (1) all required or applicable definitions;
26 (2) a description of covered services required under
27 the plan;

1 (3) a list of any exclusions or limitations to
2 coverage; and

3 (4) the deductible and coinsurance options that are
4 required or permitted under the plan. (V.T.I.C. Art. 26.44A,
5 Subsecs. (a) (part), (b), (c), (d).)

6 Sec. 1501.254. ALCOHOL AND SUBSTANCE ABUSE BENEFITS. (a)
7 This section applies only if the basic coverage health benefit plan
8 developed by the commissioner under Section 1501.253 includes
9 coverage for alcohol and substance abuse benefits.

10 (b) A small employer health benefit plan issuer may offer
11 and the employees of a small employer group may accept a basic
12 coverage health benefit plan without coverage for alcohol and
13 substance abuse benefits if:

14 (1) at least 50 percent of the employees in writing:

15 (A) waive the benefits; and

16 (B) indicate that they have undergone alcoholism
17 or substance abuse treatment or counseling within the preceding
18 three years; and

19 (2) the exclusion of those benefits applies only to
20 those employees. (V.T.I.C. Art. 26.44B.)

21 Sec. 1501.255. HEALTH MAINTENANCE ORGANIZATION PLANS. (a)
22 In this section, "point-of-service contract" means a health benefit
23 plan offered through a health maintenance organization that:

24 (1) includes corresponding indemnity benefits in
25 addition to benefits relating to out-of-area or emergency services
26 provided through insurers or group hospital service corporations;
27 and

1 (2) permits the covered individual to obtain coverage
2 under either the health maintenance organization conventional plan
3 or the indemnity plan as determined in accordance with the terms of
4 the contract.

5 (b) A health maintenance organization may offer:

6 (1) a state-approved health benefit plan that complies
7 with this chapter, Chapters 843, 1271, 1272, and 1367, Subchapter
8 A, Chapter 1452, Title XIII, Public Health Service Act (42 U.S.C.
9 Section 300e et seq.), and its subsequent amendments, and rules
10 adopted under those laws;

11 (2) a health benefit plan developed by the
12 commissioner under Section 1501.253 and additional benefit riders
13 to the plan; or

14 (3) a point-of-service contract in connection with an
15 insurer that includes optional coverage for out-of-area services,
16 emergency care, or out-of-network care.

17 (c) A point-of-service contract offered under Subsection
18 (b)(3) is subject to this chapter unless specifically exempted.
19 The insurer with which the health maintenance organization offers a
20 point-of-service contract is not required to otherwise make
21 available the health benefit plans adopted under this subchapter if
22 the insurer's small employer products are limited to the
23 point-of-service contract. (V.T.I.C. Art. 26.02, Subdiv. (23);
24 Art. 26.48.)

25 Sec. 1501.256. COORDINATION WITH FEDERAL LAW. (a) To the
26 extent required to comply with federal law applicable to a small
27 employer health benefit plan described by this subchapter, the

1 commissioner by rule may:

2 (1) modify the plan; or

3 (2) adopt a substitute for the plan.

4 (b) The commissioner shall use the Texas Health Benefits
5 Purchasing Cooperative in implementing this section. (V.T.I.C.
6 Art. 26.50.)

7 Sec. 1501.257. COST CONTAINMENT. (a) A small employer
8 health benefit plan issuer may use cost containment and managed
9 care features in a small employer health benefit plan, including:

10 (1) utilization review of health care services,
11 including review of the medical necessity of hospital and physician
12 services;

13 (2) case management, including discharge planning and
14 review of stays in hospitals or other health care facilities;

15 (3) selective contracting with hospitals, physicians,
16 and other health care providers;

17 (4) reasonable benefit differentials applicable to
18 health care providers that participate or do not participate in
19 restricted network arrangements;

20 (5) precertification or preauthorization for certain
21 covered services; and

22 (6) coordination of benefits.

23 (b) A provision of a small employer health benefit plan that
24 provides for coordination of benefits must comply with this chapter
25 and guidelines established by the commissioner.

26 (c) Utilization review performed for any cost containment,
27 case management, or managed care arrangement must comply with

1 Article 21.58A. (V.T.I.C. Art. 26.08.)

2 Sec. 1501.258. FORMS. (a) The commissioner shall:

3 (1) prescribe the benefits section of the catastrophic
4 care health benefit plan and the basic coverage health benefit plan
5 policy forms in accordance with Section 1501.253; and

6 (2) develop prototype policies for each of the health
7 benefit plans that include all contractual provisions required to
8 produce an entire contract in accordance with this code.

9 (b) With regard to each portion of the policy form for the
10 catastrophic care health benefit plan or the basic coverage health
11 benefit plan, other than the benefits section, a small employer
12 health benefit plan issuer shall comply with:

13 (1) Chapter 1701 as it relates to policy form
14 approval; and

15 (2) Chapter 1271 as it relates to evidence of coverage
16 approval.

17 (c) A small employer health benefit plan issuer may not
18 offer the catastrophic care health benefit plan or the basic
19 coverage health benefit plan through a policy form or evidence of
20 coverage that does not comply with this chapter. (V.T.I.C. Art.
21 26.43, Subsec. (a); Art. 26.44A, Subsec. (a) (part).)

22 Sec. 1501.259. RIDERS; FILING WITH COMMISSIONER. (a) A
23 small employer health benefit plan issuer shall file with the
24 commissioner, in a form and manner prescribed by the commissioner,
25 each rider to a small employer health benefit plan to be used by the
26 issuer, as authorized by Section 1501.252.

27 (b) A small employer health benefit plan issuer may use a

1 rider filed under this section after the 30th day after the date the
2 rider is filed unless the commissioner disapproves its use.

3 (c) The commissioner, after notice and an opportunity for a
4 hearing, may disapprove the continued use of a rider by a small
5 employer health benefit plan issuer if the rider does not meet the
6 requirements of this chapter and other applicable statutes.
7 (V.T.I.C. Art. 26.44.)

8 Sec. 1501.260. PLAIN LANGUAGE REQUIRED. (a) A health
9 benefit plan issuer may not issue and the commissioner may not
10 approve a health benefit plan certificate or policy or a rider to a
11 health benefit plan certificate or policy unless it is written in
12 plain language.

13 (b) Each provision of a health benefit plan certificate or
14 policy or a rider to a health benefit plan certificate or policy
15 relating to renewal of coverage, conditions of coverage, or per
16 occurrence or aggregate dollar limitations on coverage must be
17 clearly explained in plain language.

18 (c) A health benefit plan issuer may not use and the
19 commissioner may not approve a health benefit plan application form
20 unless it is written in plain language.

21 (d) Subsections (a)-(c) do not apply if the specific
22 language to be used is required by federal law or state statute or
23 by rules implementing federal law.

24 (e) For purposes of Subsections (a)-(d), a health benefit
25 plan certificate or policy, a rider to or a provision of a health
26 benefit plan certificate or policy, or a health benefit plan
27 application form is written in plain language if it achieves the

1 minimum score established by the commissioner on the Flesch reading
2 ease test or an equivalent test selected by the commissioner.

3 (f) This section does not apply to:

4 (1) a health benefit plan group master policy; or

5 (2) a policy application or enrollment form for a
6 health benefit plan group master policy. (V.T.I.C. Art. 26.43,
7 Subsecs. (b), (c), (d), (e), (f), (g).)

8 [Sections 1501.261-1501.300 reserved for expansion]

9 SUBCHAPTER G. REINSURANCE FOR SMALL EMPLOYER

10 HEALTH BENEFIT PLANS

11 Sec. 1501.301. DEFINITIONS. In this subchapter:

12 (1) "Board" means the board of directors of the Texas
13 Health Reinsurance System.

14 (2) "Plan of operation" means the plan of operation of
15 the system established under Section 1501.306.

16 (3) "Reinsured health benefit plan issuer" means a
17 small employer health benefit plan issuer that participates in the
18 system.

19 (4) "Risk-assuming health benefit plan issuer" means a
20 small employer health benefit plan issuer that does not participate
21 in the system.

22 (5) "System" means the Texas Health Reinsurance System
23 established under this subchapter. (V.T.I.C. Art. 26.02, Subdivs.
24 (4), (22), (27); Art. 26.02, Subdiv. (33), as amended Acts 77th
25 Leg., R.S., Ch. 823; Art. 26.02, Subdivs. (28), (32), as amended
26 Acts 77th Leg., R.S., Ch. 608.)

27 Sec. 1501.302. TEXAS HEALTH REINSURANCE SYSTEM. The Texas

1 Health Reinsurance System is a nonprofit entity administered by a
2 board of directors and subject to the supervision and control of the
3 commissioner. (V.T.I.C. Art. 26.53.)

4 Sec. 1501.303. SYSTEM BOARD OF DIRECTORS. (a) The board of
5 directors of the system is composed of:

6 (1) nine members appointed by the commissioner; and
7 (2) the commissioner or the commissioner's
8 representative, who serves as an ex officio member.

9 (b) Five of the appointed members must be representatives of
10 reinsured health benefit plan issuers selected from individuals
11 nominated by small employer health benefit plan issuers in this
12 state according to procedures developed by the commissioner.

13 (c) Four of the appointed members must represent the public.
14 A member representing the public may not:

15 (1) be an officer, director, or employee of an
16 insurance company, agency, agent, broker, solicitor, or adjuster or
17 any other business entity regulated by the department;

18 (2) be a person required to register under Chapter
19 305, Government Code; or

20 (3) be related to a person described by Subdivision
21 (1) or (2) within the second degree by affinity or consanguinity.

22 (d) Appointed members serve two-year terms expiring
23 December 31 of each odd-numbered year. A member's term continues
24 until a successor is appointed.

25 (e) A member of the board may not be compensated for serving
26 on the board but is entitled to reimbursement for actual expenses
27 incurred in performing functions as a member of the board as

1 provided by the General Appropriations Act. (V.T.I.C. Art. 26.54,
2 Subsecs. (a), (b), (c).)

3 Sec. 1501.304. OPEN MEETINGS; PUBLIC INFORMATION. The
4 board is subject to:

5 (1) the open meetings law, Chapter 551, Government
6 Code; and

7 (2) the public information law, Chapter 552,
8 Government Code. (V.T.I.C. Art. 26.54, Subsec. (d).)

9 Sec. 1501.305. BOARD MEMBER IMMUNITY. (a) A member of the
10 board is not liable for an act performed, or omission made, in good
11 faith in the performance of powers and duties under this
12 subchapter.

13 (b) A cause of action does not arise against a member of the
14 board for an act or omission described by Subsection (a). (V.T.I.C.
15 Art. 26.54, Subsec. (e).)

16 Sec. 1501.306. SYSTEM PLAN OF OPERATION. (a) The board
17 shall submit to the commissioner a plan of operation and any
18 amendments to that plan necessary or suitable to ensure the fair,
19 reasonable, and equitable administration of the system.

20 (b) The commissioner, after notice and hearing, may approve
21 the plan of operation if the commissioner determines the plan:

22 (1) is suitable to ensure the fair, reasonable, and
23 equitable administration of the system; and

24 (2) provides for the sharing of system gains or losses
25 on an equitable and proportionate basis in accordance with this
26 subchapter.

27 (c) The plan of operation is effective on the written

1 approval of the commissioner.

2 (d) The plan of operation must:

3 (1) establish procedures for:

4 (A) handling and accounting for system assets and
5 money;

6 (B) making an annual fiscal report to the
7 commissioner;

8 (C) selecting an administering health benefit
9 plan issuer or third-party administrator and establishing the
10 powers and duties of the administering issuer or third-party
11 administrator;

12 (D) reinsuring risks in accordance with this
13 subchapter; and

14 (E) collecting assessments from reinsured health
15 benefit plan issuers to fund claims and administrative expenses
16 incurred or estimated to be incurred by the system, including the
17 imposition of penalties for late payment of an assessment; and

18 (2) provide for any additional matter necessary to
19 implement and administer the system. (V.T.I.C. Art. 26.55,
20 Subsecs. (a) (part), (c).)

21 Sec. 1501.307. SYSTEM POWERS. (a) The system has the
22 general powers and authority granted under state law to an insurer
23 or a health maintenance organization authorized to engage in
24 business, except that the system may not directly issue a health
25 benefit plan.

26 (b) The system may:

27 (1) enter into contracts necessary or proper to

1 implement this subchapter, including, with the commissioner's
2 approval, contracts with similar programs of other states for the
3 joint performance of common functions or with persons or other
4 organizations for the performance of administrative functions;

5 (2) sue or be sued, including taking legal action
6 necessary or proper to recover assessments and penalties for, on
7 behalf of, or against the system or a reinsured health benefit plan
8 issuer;

9 (3) take legal action necessary to avoid the payment
10 of improper claims against the system;

11 (4) issue reinsurance contracts in accordance with
12 this subchapter;

13 (5) establish guidelines, conditions, and procedures
14 for reinsuring risks under the plan of operation;

15 (6) establish actuarial functions as appropriate for
16 the operation of the system;

17 (7) assess reinsured health benefit plan issuers in
18 accordance with Sections 1501.319-1501.323;

19 (8) appoint appropriate legal, actuarial, and other
20 committees necessary to provide technical assistance in:

21 (A) the operation of the system;

22 (B) policy and other contract design; and

23 (C) any other function within the authority of
24 the system; and

25 (9) borrow money for a period not to exceed one year to
26 accomplish the purposes of the system.

27 (c) The system is exempt from all taxes. (V.T.I.C. Art.

1 26.56 (part).)

2 Sec. 1501.308. SYSTEM NOTES AS LEGAL INVESTMENT FOR SMALL
3 EMPLOYER HEALTH BENEFIT PLAN ISSUER. A note or other evidence of
4 indebtedness of the system that is not in default is a legal
5 investment for a small employer health benefit plan issuer and may
6 be carried as an admitted asset. (V.T.I.C. Art. 26.56 (part).)

7 Sec. 1501.309. SYSTEM AUDIT. (a) The transactions of the
8 system are subject to audit by the state auditor in accordance with
9 Chapter 321, Government Code.

10 (b) The state auditor shall report the cost of each audit
11 conducted under this section to the board and the comptroller, and
12 the board shall remit that amount to the comptroller. (V.T.I.C.
13 Art. 26.57.)

14 Sec. 1501.310. ELECTION OF STATUS. (a) Each small employer
15 health benefit plan issuer shall notify the commissioner of the
16 issuer's election to operate as a risk-assuming health benefit plan
17 issuer or as a reinsured health benefit plan issuer. An issuer that
18 elects to operate as a risk-assuming health benefit plan issuer
19 shall file an application in accordance with Section 1501.312.

20 (b) A small employer health benefit plan issuer's election
21 under this section is effective until the fifth anniversary of the
22 date of the election.

23 (c) The commissioner may permit a small employer health
24 benefit plan issuer to modify its election at any time for good
25 cause shown. (V.T.I.C. Art. 26.51, Subsecs. (a), (b).)

26 Sec. 1501.311. CHANGE IN STATUS. (a) The commissioner
27 shall establish an application process for a small employer health

benefit plan issuer that elects to change its status under this subchapter.

(b) A reinsured health benefit plan issuer that elects to change its status to operate as a risk-assuming health benefit plan issuer may not continue to reinsure a small employer health benefit plan with the system. The issuer shall pay a prorated assessment based on business issued as a reinsured health benefit plan issuer for the portion of the year the business was reinsured. (V.T.I.C. Art. 26.51, Subsecs. (c), (d).)

Sec. 1501.312. APPLICATION TO OPERATE AS RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. (a) A small employer health benefit plan issuer may apply to operate as a risk-assuming health benefit plan issuer by filing an application with the commissioner in a form and manner prescribed by the commissioner.

(b) In evaluating an application, the commissioner shall consider the small employer health benefit plan issuer's:

- (1) financial condition;
- (2) history of rating and underwriting small employer groups;
- (3) commitment to market fairly to all small employers in the state or in the issuer's established geographic service area; and
- (4) experience managing the risk of small employer groups.

(c) The commissioner shall provide public notice of an application and shall provide at least a 60-day period for public comment before making a decision on the application. If the

1 commissioner does not act on the application before the 90th day
2 after the date the commissioner receives the application, the
3 issuer may request and the commissioner shall grant a hearing.
4 (V.T.I.C. Art. 26.52, Subsecs. (a), (b), (c).)

5 Sec. 1501.313. RESCISSION OF APPROVAL TO OPERATE AS
6 RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. The commissioner, after
7 notice and hearing, may rescind approval to operate as a
8 risk-assuming health benefit plan issuer if the commissioner finds
9 that the issuer:

10 (1) is not financially able to support the assumption
11 of risk from issuing coverage to small employers without the
12 protection provided by the system;

13 (2) has failed to market fairly to all small employers
14 in the state or in the issuer's established geographic service
15 area; or

16 (3) has failed to provide coverage to eligible small
17 employers. (V.T.I.C. Art. 26.52, Subsec. (d).)

18 Sec. 1501.314. REINSURANCE. (a) A small employer health
19 benefit plan issuer may reinsure risks covered under a small
20 employer health benefit plan with the system as provided by this
21 subchapter.

22 (b) The system shall reinsure the level of coverage provided
23 under the small employer health benefit plan.

24 (c) A small employer health benefit plan issuer may
25 reinsure:

26 (1) an entire small employer group not later than the
27 60th day after the date the group's coverage under the small

1 employer health benefit plan takes effect;

2 (2) an eligible employee of a small employer or the
3 employee's dependent not later than the 60th day after the date the
4 person's coverage takes effect; or

5 (3) a newly eligible employee of a reinsured small
6 employer group, the employee's dependent, or an individual covered
7 under the small employer health benefit plan not later than the 60th
8 day after the date the individual's coverage takes effect.
9 (V.T.I.C. Art. 26.58, Subsecs. (a), (b), (c).)

10 Sec. 1501.315. LIMITS ON REINSURANCE. (a) The system may
11 not reimburse a reinsured health benefit plan issuer for the claims
12 of a reinsured individual until the issuer has incurred an initial
13 level of claims of \$5,000 in a calendar year for that individual for
14 benefits covered by the system. In addition, the reinsured health
15 benefit plan issuer is responsible for 10 percent of the next
16 \$50,000 of benefit payments during a calendar year, and the system
17 shall reinsure the remainder. A reinsured health benefit plan
18 issuer's liability to a reinsured individual may not exceed a
19 maximum of \$10,000 in a calendar year.

20 (b) The board annually shall adjust the initial level of
21 claims and the maximum liability to be retained by a reinsured
22 health benefit plan issuer under Subsection (a) to reflect
23 increases in:

24 (1) costs; and

25 (2) the use of small employer health benefit plans in
26 this state.

27 (c) An adjustment under Subsection (b) may not be less than

1 the annual change in the medical component of the Consumer Price
2 Index for All Urban Consumers published by the Bureau of Labor
3 Statistics of the United States Department of Labor unless the
4 board proposes and the commissioner approves a lower adjustment
5 factor. (V.T.I.C. Art. 26.58, Subsecs. (d), (e).)

6 Sec. 1501.316. TERMINATION OF REINSURANCE. A small
7 employer health benefit plan issuer may terminate reinsurance with
8 the system for one or more reinsured employees or dependents of
9 employees of a small employer on a contract anniversary of the small
10 employer health benefit plan. (V.T.I.C. Art. 26.58, Subsec. (f).)

11 Sec. 1501.317. APPLICATION OF MANAGED CARE PROCEDURES.
12 Except as provided by the plan of operation, a reinsured health
13 benefit plan issuer shall apply consistently with respect to
14 reinsured and nonreinsured business all managed care procedures,
15 including utilization review, individual case management,
16 preferred provider provisions, and other managed care provisions or
17 methods of operation. (V.T.I.C. Art. 26.58, Subsec. (g).)

18 Sec. 1501.318. PREMIUM RATES FOR REINSURANCE. (a) As part
19 of the plan of operation, the board shall adopt a method to
20 determine premium rates to be charged by the system for reinsuring
21 small employer groups and individuals under this subchapter.

22 (b) The method adopted must:

23 (1) include a classification system for small employer
24 groups that reflects the variations in premium rates allowed by
25 this chapter; and

26 (2) provide for the development of base reinsurance
27 premium rates that reflect the allowable variations.

1 (c) Subject to approval by the commissioner, the board shall
2 establish the base reinsurance premium rates at levels that
3 reasonably approximate the gross premiums charged to small
4 employers by small employer health benefit plan issuers for small
5 employer health benefit plans, adjusted to reflect retention levels
6 required under this subchapter.

7 (d) The board shall periodically review the method adopted
8 under this section, including the classification system and any
9 rating factors, to ensure that the method reasonably reflects the
10 claims experience of the system. The board may propose changes to
11 the method. Any changes are subject to approval by the
12 commissioner.

13 (e) An entire small employer group may be reinsured at a
14 rate that is 1-1/2 times the base reinsurance premium rate for that
15 group. An eligible employee of a small employer or the employee's
16 dependent covered under a small employer health benefit plan may be
17 reinsured at a rate that is five times the base reinsurance premium
18 rate for that individual.

19 (f) The board may consider adjustments to the premium rates
20 charged by the system to reflect the use of effective cost
21 containment and managed care arrangements. (V.T.I.C. Art. 26.59.)

22 Sec. 1501.319. DETERMINATION OF NET LOSS. (a) Not later
23 than March 1 of each year, the board shall determine the system's
24 net loss for the preceding calendar year, including administrative
25 expenses and incurred losses for the year, and report the net loss
26 to the commissioner.

27 (b) In determining the net loss, the board shall take into

1 account investment income and other appropriate gains and losses.
2 (V.T.I.C. Art. 26.60, Subsec. (a) (part).)

3 Sec. 1501.320. ASSESSMENTS TO RECOVER NET LOSSES. (a) The
4 board shall recover any net loss of the system by assessing each
5 reinsured health benefit plan issuer an amount determined annually
6 by the board based on information in annual statements and other
7 reports required by and filed with the board.

8 (b) The board shall establish, as part of the plan of
9 operation, a formula by which to make assessments against reinsured
10 health benefit plan issuers. With the approval of the
11 commissioner, the board may periodically change the assessment
12 formula as appropriate. The board shall base the assessment
13 formula on each reinsured issuer's share of:

14 (1) the total premiums earned in the preceding
15 calendar year from small employer health benefit plans delivered or
16 issued for delivery by reinsured health benefit plan issuers to
17 small employer groups in this state; and

18 (2) the premiums earned in the preceding calendar year
19 from newly issued small employer health benefit plans delivered or
20 issued for delivery during the calendar year by reinsured health
21 benefit plan issuers to small employer groups in this state.
22 (V.T.I.C. Art. 26.60, Subsec. (a) (part).)

23 Sec. 1501.321. LIMITS ON ASSESSMENTS. (a) The formula
24 established under Section 1501.320(b) may not result in an
25 assessment for a reinsured health benefit plan issuer that is less
26 than 50 percent or more than 150 percent of an amount based on the
27 proportion of the total premiums earned in the preceding calendar

1 year from small employer health benefit plans delivered or issued
2 for delivery to small employer groups in this state by that issuer
3 to the total premiums earned in the preceding calendar year from
4 small employer health benefit plans delivered or issued for
5 delivery to small employer groups in this state by all reinsured
6 health benefit plan issuers.

7 (b) In determining assessments, the board may not consider
8 premiums earned by a reinsured health benefit plan issuer that are
9 less than an amount determined by the board to justify the cost of
10 collecting an assessment based on those premiums. (V.T.I.C. Art.
11 26.60, Subsec. (b).)

12 Sec. 1501.322. ADJUSTMENT TO ASSESSMENTS ON FEDERALLY
13 QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS. With the
14 commissioner's approval, the board may adjust the formula
15 established under Section 1501.320(b) for a reinsured health
16 benefit plan issuer that is an approved health maintenance
17 organization that is federally qualified under Title XIII, Public
18 Health Service Act (42 U.S.C. Section 300e et seq.), to the extent
19 that any restriction is imposed on that issuer that is not imposed
20 on other issuers. (V.T.I.C. Art. 26.60, Subsec. (c).)

21 Sec. 1501.323. ADVANCE INTERIM ASSESSMENTS. (a) The
22 system may make advance interim assessments as reasonable and
23 necessary for organizational and interim operating expenses.

24 (b) After the end of the fiscal year, the system shall
25 credit an interim assessment made under this section as an offset
26 against regular assessments due. (V.T.I.C. Art. 26.56 (part).)

27 Sec. 1501.324. LIMIT ON TOTAL ASSESSMENTS. The maximum

1 assessment amount payable for a calendar year may not exceed five
2 percent of the total premiums earned in the preceding calendar year
3 from small employer health benefit plans delivered or issued for
4 delivery by reinsured health benefit plan issuers in this state.
5 (V.T.I.C. Art. 26.61, Subsec. (f).)

6 Sec. 1501.325. ESTIMATE OF ASSESSMENTS; EVALUATION AND
7 PROTECTION OF SYSTEM. (a) Not later than March 1 of each year, the
8 board shall file with the commissioner an estimate of the
9 assessments necessary to fund the losses for small employer groups
10 incurred by the system during the preceding calendar year.

11 (b) If the board determines that the necessary assessments
12 exceed five percent of the total premiums earned in the preceding
13 calendar year from small employer health benefit plans delivered or
14 issued for delivery by reinsured health benefit plan issuers to
15 small employer groups in this state, the board shall evaluate the
16 operation of the system and shall report its findings, including
17 any recommendations for changes to the plan of operation, to the
18 commissioner not later than April 1 of the year following the
19 calendar year in which the losses were incurred. The evaluation
20 must:

21 (1) include an estimate of future assessments; and

22 (2) consider:

23 (A) the administrative costs of the system;

24 (B) the appropriateness of the premiums charged;

25 (C) the level of health benefit plan issuer
26 retention under the system; and

27 (D) the costs of coverage for small employer

1 groups.

2 (c) If the board fails to timely file a report required by
3 Subsection (b), the commissioner may:

4 (1) evaluate the operations of the system; and

5 (2) implement amendments to the plan of operation that
6 the commissioner considers necessary to reduce future losses and
7 assessments.

8 (d) A reinsured health benefit plan issuer may not write
9 small employer health benefit plans on a guaranteed issue basis
10 during a calendar year if the assessment amount payable for the
11 preceding calendar year is at least five percent of the total
12 premiums earned in that calendar year from small employer health
13 benefit plans delivered or issued for delivery by reinsured health
14 benefit plan issuers in this state.

15 (e) A reinsured health benefit plan issuer may not write
16 small employer health benefit plans on a guaranteed issue basis
17 after the board determines that the expected loss from the
18 reinsurance system for a year will exceed the total amount of
19 assessments payable at a rate of five percent of the total premiums
20 earned for the preceding calendar year. A reinsured health benefit
21 plan issuer may not resume writing small employer health benefit
22 plans on a guaranteed issue basis until the board determines that
23 the expected loss will be less than the maximum established by this
24 subsection. (V.T.I.C. Art. 26.61, Subsecs. (a), (b), (c), (d),
25 (e).)

26 Sec. 1501.326. DEFERMENT OF ASSESSMENT. (a) A reinsured
27 health benefit plan issuer may petition the commissioner for a

1 deferment in whole or in part of an assessment imposed by the board.

2 (b) The commissioner may defer all or part of the assessment
3 if the commissioner determines that payment of the assessment would
4 endanger the ability of the reinsured health benefit plan issuer to
5 fulfill its contractual obligations.

6 (c) The board shall assess the amount of a deferred
7 assessment against other reinsured health benefit plan issuers in a
8 manner consistent with the basis for assessment established by this
9 subchapter.

10 (d) A reinsured health benefit plan issuer that receives a
11 deferment:

12 (1) is liable to the system for the amount deferred;
13 and

14 (2) until the issuer pays the outstanding assessment,
15 may not:

16 (A) market, deliver, or issue for delivery a
17 small employer health benefit plan; or

18 (B) reinsure any individual or group with the
19 system. (V.T.I.C. Art. 26.62.)

20 [Sections 1501.327-1501.350 reserved for expansion]

21 SUBCHAPTER H. MARKETING OF SMALL EMPLOYER HEALTH

22 BENEFIT PLANS

23 Sec. 1501.351. MARKETING REQUIREMENTS. (a) Each small
24 employer health benefit plan issuer shall market a small employer
25 health benefit plan to eligible small employers in this state
26 through properly licensed agents.

27 (b) Each small employer purchasing a small employer health

1 benefit plan must be given a summary, in a format prescribed by the
2 commissioner, of the health benefit plans established by the
3 commissioner under Subchapter F.

4 (c) An agent shall offer and explain to a small employer on
5 inquiry and request by the employer each health benefit plan
6 established by the commissioner under Subchapter F. (V.T.I.C. Art.
7 26.71, Subsec. (a).)

8 Sec. 1501.352. HEALTH STATUS AND CLAIMS EXPERIENCE;
9 PROHIBITED ACTS. (a) A small employer health benefit plan issuer
10 or agent may not, because of the health status or claims experience
11 of the eligible employees of a small employer and those employees'
12 dependents, directly or indirectly encourage or direct the employer
13 to:

14 (1) refrain from applying for coverage with the
15 issuer;

16 (2) seek coverage from another issuer; or

17 (3) apply for a particular small employer health
18 benefit plan.

19 (b) A small employer health benefit plan issuer may not
20 directly or indirectly enter into an agreement or arrangement with
21 an agent that provides for or results in compensation paid to the
22 agent for the sale of small employer health benefit plans that
23 varies because of health status or claims experience.

24 (c) Subsection (b) does not apply to an arrangement that
25 provides compensation to an agent based on a percentage of premium,
26 except that the percentage may not vary because of health status or
27 claims experience.

1 (d) A small employer health benefit plan issuer or agent may
2 not encourage a small employer to exclude an eligible employee from
3 health coverage provided in connection with the employee's
4 employment.

5 (e) A small employer health benefit plan issuer may not
6 terminate, fail to renew, or limit its contract or agreement of
7 representation with an agent for a reason related to the health
8 status or claims experience of a small employer group placed by the
9 agent with the issuer. (V.T.I.C. Art. 26.72; Art. 26.73, Subsec.
10 (b).)

11 Sec. 1501.353. AGENT COMPENSATION. (a) A small employer
12 health benefit plan issuer shall pay the same commission,
13 percentage of premium, or other amount to an agent for renewal of a
14 small employer health benefit plan as the issuer paid for original
15 placement of the plan, except that the issuer may increase
16 compensation for renewal of a plan to reflect an increase in the
17 cost of living or similar factors.

18 (b) A small employer health benefit plan issuer may not
19 implement, directly or indirectly, agent commission schedules that
20 vary the level of agent commissions based on the size of the group
21 or otherwise reduce access to small employer health benefit plans.

22 (c) Notwithstanding Subsection (b), a small employer health
23 benefit plan issuer may:

24 (1) vary agent commission amounts or percentages
25 based on group size if the variation in the commission amounts or
26 percentages are inversely related to the size of the group;

27 (2) vary agent commission amounts or percentages based

1 on the cumulative premium paid by a single small employer over a
2 specific period if the variation in the commission amounts or
3 percentages are inversely related to the cumulative premium paid
4 during the period; or

5 (3) pay agent commissions as a percentage of premiums
6 charged to a small employer if the commission percentage is based on
7 all premiums paid by the small employer. (V.T.I.C. Art. 26.73,
8 Subsecs. (a), (c), (d).)

9 Sec. 1501.354. REQUIRED DISCLOSURES. (a) In connection
10 with offering a small employer health benefit plan for sale, each
11 small employer health benefit plan issuer and agent shall make a
12 reasonable disclosure, as part of its solicitation and sales
13 materials, of:

14 (1) the extent to which premium rates for a specific
15 small employer are established or adjusted based on the actual or
16 expected variation in:

17 (A) claim costs; or

18 (B) health status of the employer's employees and
19 their dependents;

20 (2) provisions concerning the issuer's right to change
21 premium rates and factors other than claims experience that affect
22 changes in premium rates;

23 (3) provisions relating to renewability of policies
24 and contracts; and

25 (4) any preexisting condition provisions.

26 (b) On request by a small employer, each small employer
27 health benefit plan issuer shall disclose the benefits and premiums

1 available under all small employer coverage for which the employer
2 is qualified.

3 (c) A small employer health benefit plan issuer is not
4 required to disclose information to a small employer that is
5 proprietary or trade secret information under applicable law.

6 (d) Information provided under this section to a small
7 employer must be provided in a manner that is:

8 (1) understandable by the average small employer; and

9 (2) sufficient to reasonably inform a small employer
10 of its rights and obligations under a small employer health benefit
11 plan. (V.T.I.C. Art. 26.40.)

12 Sec. 1501.355. RULES CONCERNING MARKETING AND
13 AVAILABILITY. Rules adopted under Section 1501.010 may establish
14 additional standards to provide for the fair marketing and broad
15 availability of small employer health benefit plans to small
16 employers in this state. (V.T.I.C. Art. 26.75.)

17 Sec. 1501.356. REPORTING REQUIREMENTS. (a) In this
18 section, "case characteristics" has the meaning assigned by Section
19 1501.201.

20 (b) The department may require periodic reports by small
21 employer health benefit plan issuers and agents regarding small
22 employer health benefit plans issued by those issuers and agents.
23 The reporting requirements must include information regarding:

24 (1) case characteristics; and

25 (2) the number of small employer health benefit plans
26 in various categories that are marketed or issued to small
27 employers. (V.T.I.C. Art. 26.71, Subsec. (b).)

1 Sec. 1501.357. VIOLATIONS. A violation of Section 1501.352
2 by a small employer health benefit plan issuer or agent is an unfair
3 method of competition and an unfair or deceptive act or practice
4 under Chapter 541. (V.T.I.C. Art. 26.76, Subsec. (a).)

5 Sec. 1501.358. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR.
6 If a small employer health benefit plan issuer enters into an
7 agreement with a third-party administrator to provide
8 administrative, marketing, or other services related to offering
9 small employer health benefit plans to small employers in this
10 state, the third-party administrator is subject to Sections
11 1501.111, 1501.351-1501.353, and 1501.355-1501.357. (V.T.I.C.
12 Art. 26.76, Subsec. (b).)

13 [Subchapters I-L reserved for expansion]

14 SUBCHAPTER M. LARGE EMPLOYER HEALTH BENEFIT PLANS

15 Sec. 1501.601. PARTICIPATION CRITERIA. (a) In this
16 subchapter, "participation criteria" means any criteria or rules
17 established by a large employer to determine the employees who are
18 eligible for enrollment or continued enrollment under the terms of
19 a health benefit plan.

20 (b) The participation criteria may not be based on health
21 status related factors. (V.T.I.C. Art. 26.02, Subdiv. (20); Art.
22 26.83, Subsec. (a) (part).)

23 Sec. 1501.602. COVERAGE REQUIREMENTS. (a) A large
24 employer health benefit plan issuer:

25 (1) may refuse to provide coverage to a large employer
26 in accordance with the issuer's underwriting standards and
27 criteria;

1 (2) shall accept or reject the entire group of
2 individuals who meet the participation criteria and choose
3 coverage; and

4 (3) may exclude only those employees or dependents who
5 decline coverage.

6 (b) On issuance of a health benefit plan to a large
7 employer, a large employer health benefit plan issuer shall provide
8 coverage to the employees who meet the participation criteria
9 without regard to an individual's health status related factors.
10 (V.T.I.C. Art. 26.83, Subsecs. (a) (part), (b) (part).)

11 Sec. 1501.603. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT
12 PROHIBITED. A large employer health benefit plan issuer may not
13 exclude an employee who meets the participation criteria or an
14 eligible dependent, including a late enrollee, who would otherwise
15 be covered under a large employer group. (V.T.I.C. Art. 26.83,
16 Subsec. (1).)

17 Sec. 1501.604. DECLINING COVERAGE. (a) A large employer
18 health benefit plan issuer shall obtain a written waiver from each
19 employee who meets the participation criteria and declines coverage
20 under a health benefit plan offered to a large employer. The waiver
21 must ensure that the employee was not induced or pressured to
22 decline coverage because of the employee's health status related
23 factors.

24 (b) A large employer health benefit plan issuer may not
25 provide coverage to a large employer or the employer's employees if
26 the issuer or an agent for the issuer knows that the employer has
27 induced or pressured an employee who meets the participation

1 criteria or a dependent of the employee to decline coverage because
2 of the individual's health status related factors. (V.T.I.C. Art.
3 26.83, Subsecs. (c), (d).)

4 Sec. 1501.605. MINIMUM CONTRIBUTION OR PARTICIPATION
5 REQUIREMENTS. (a) A large employer health benefit plan issuer may
6 require a large employer to meet a minimum contribution or
7 participation requirement as a condition of issuance or renewal in
8 accordance with the issuer's usual and customary practices for all
9 the issuer's employer health benefit plans in this state.

10 (b) A participation requirement may determine the
11 percentage of eligible employees who meet the participation
12 criteria and who must be enrolled in the health benefit plan.

13 (c) A large employer health benefit plan issuer may apply a
14 participation requirement to a large employer's eligible
15 employees, but may not apply the requirement to eligible dependents
16 of those employees.

17 (d) A participation requirement must be stated in the health
18 benefit plan contract and must be applied uniformly to each large
19 employer offered or issued coverage by a large employer health
20 benefit plan issuer in this state. (V.T.I.C. Art. 26.83, Subsec.
21 (e).)

22 Sec. 1501.606. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a)
23 The initial enrollment period for employees meeting the
24 participation criteria under a large employer health benefit plan
25 must be at least 31 days, with a 31-day annual open enrollment
26 period.

27 (b) A large employer may establish a waiting period. The

1 employer shall determine the duration of the waiting period.

2 (c) A new employee who meets the participation criteria may
3 not be denied coverage if the application for coverage is received
4 by the large employer not later than the 31st day after the later
5 of:

6 (1) the date employment begins; or

7 (2) the date the waiting period established under
8 Subsection (b) expires.

9 (d) If dependent coverage is offered to the enrollees under
10 a large employer health benefit plan:

11 (1) the initial enrollment period for the dependents
12 must be at least 31 days, with a 31-day annual open enrollment
13 period; and

14 (2) a dependent of a new employee who meets the
15 participation criteria may not be denied coverage if the
16 application for coverage is received by the large employer not
17 later than the 31st day after the latest of:

18 (A) the date on which the employment begins;

19 (B) the date the waiting period established under
20 Subsection (b) expires; or

21 (C) the date the dependent becomes eligible for
22 enrollment.

23 (e) A late enrollee may be excluded from coverage until the
24 next annual open enrollment period and may be subject to a one-year
25 preexisting condition provision as described by Section 1501.102.
26 The period during which a preexisting condition provision applies
27 may not exceed 18 months from the date of the initial application.

1 (V.T.I.C. Art. 26.83, Subsecs. (f), (g), (h), (i), (j), (k).)

2 Sec. 1501.607. COVERAGE FOR NEWBORN CHILDREN. (a) A large
3 employer health benefit plan may not limit or exclude initial
4 coverage of a newborn child of a covered employee.

5 (b) Coverage of a newborn child of a covered employee under
6 this section ends on the 32nd day after the date of the child's
7 birth unless:

8 (1) children are eligible for coverage under the large
9 employer health benefit plan; and

10 (2) not later than the 31st day after the date of
11 birth, the large employer health benefit plan issuer receives:

12 (A) notice of the birth; and

13 (B) any required additional premium. (V.T.I.C.
14 Art. 26.84, Subsec. (a).)

15 Sec. 1501.608. COVERAGE FOR ADOPTED CHILDREN. (a) This
16 section applies only if children are eligible for coverage under a
17 large employer health benefit plan.

18 (b) A large employer health benefit plan may not limit or
19 exclude initial coverage of an adopted child of an insured. A child
20 is considered to be the adopted child of an insured if the insured
21 is a party to a suit in which the insured seeks to adopt the child.

22 (c) An adopted child of an insured may be enrolled, at the
23 insured's option, not later than the 31st day after:

24 (1) the date the insured becomes a party to a suit in
25 which the insured seeks to adopt the child; or

26 (2) the date the adoption becomes final.

27 (d) Coverage of an adopted child of an insured under this

1 section ends unless the large employer health benefit plan issuer
2 receives notice of the adoption and any required additional premium
3 not later than the 31st day after:

4 (1) the date the insured becomes a party to a suit in
5 which the insured seeks to adopt the child; or

6 (2) the date the adoption becomes final. (V.T.I.C.
7 Art. 26.84, Subsecs. (b), (c), (d).)

8 Sec. 1501.609. COVERAGE FOR UNMARRIED CHILDREN. (a) This
9 section applies only if children are eligible for coverage under a
10 large employer health benefit plan.

11 (b) Any limiting age applicable under a large employer
12 health benefit plan to an unmarried child of an enrollee is 25 years
13 of age. (V.T.I.C. Art. 26.84, Subsec. (e).)

14 Sec. 1501.610. PREMIUM RATES; ADJUSTMENTS. (a) A large
15 employer health benefit plan issuer may charge premiums in
16 accordance with this section to the group of employees or
17 dependents who meet the participation criteria and do not decline
18 coverage.

19 (b) A large employer health benefit plan issuer may not
20 charge an adjustment to premium rates for individual employees or
21 dependents for health status related factors or duration of
22 coverage. Any adjustment must be applied uniformly to the rates
23 charged for all employees and dependents of employees of a large
24 employer.

25 (c) Subsection (b) does not restrict the amount that a large
26 employer may be charged for coverage. (V.T.I.C. Art. 26.83,
27 Subsec. (b) (part); Art. 26.89, Subsec. (a).)

1 Sec. 1501.611. MARKETING REQUIREMENTS. On request, each
2 large employer purchasing a health benefit plan shall be given a
3 summary of all plans for which the employer is eligible. (V.T.I.C.
4 Art. 26.91, Subsec. (a).)

5 Sec. 1501.612. ENCOURAGING EXCLUSION OF EMPLOYEE
6 PROHIBITED. A large employer health benefit plan issuer or agent
7 may not encourage a large employer to exclude an employee who meets
8 the participation criteria from health coverage provided in
9 connection with the employee's employment. (V.T.I.C. Art. 26.92.)

10 Sec. 1501.613. AGENTS. A large employer health benefit
11 plan issuer may not terminate, fail to renew, or limit its contract
12 or agreement of representation with an agent because of health
13 status related factors of a large employer group placed by the agent
14 with the issuer. (V.T.I.C. Art. 26.93.)

15 Sec. 1501.614. REPORTING OF CLAIMS INFORMATION. (a) This
16 section applies only to an insured employer health benefit plan.

17 (b) An employer carrier, on written request from an insured
18 employer covered by that carrier, shall report to the employer
19 information from the 12 months preceding the date of the report
20 regarding:

21 (1) the total amount of charges submitted to the
22 carrier for persons covered under the employer health benefit plan;

23 (2) the total amount of payments made by the carrier to
24 health care providers for persons covered under the plan; and

25 (3) to the extent available, information on claims
26 paid by type of health care provider, including total hospital
27 charges, physician charges, pharmaceutical charges, and other

1 charges.

2 (c) An employer carrier shall provide information requested
3 by an employer under this section annually not later than the 30th
4 day before the anniversary or renewal date of the employer's health
5 benefit plan.

6 (d) Notwithstanding Subsection (c), an employer carrier is
7 not required to provide information under Subsection (b) earlier
8 than the 30th day after the date of the initial written request.

9 (e) An employer carrier may not report any information
10 required under this section if the release of the information is
11 prohibited by federal law or regulation.

12 (f) An employer carrier shall provide claim information
13 under this section in the aggregate, without information through
14 which a specific individual covered by the health insurance or
15 evidence of coverage may be identified. (V.T.I.C. Art. 26.96.)

16 Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS. The
17 department may require periodic reports by large employer health
18 benefit plan issuers and agents regarding the large employer health
19 benefit plans issued by those issuers. The reporting requirements
20 must:

21 (1) require information regarding the number of plans
22 in various categories that are marketed or issued to large
23 employers; and

24 (2) comply with federal law, including regulations.
25 (V.T.I.C. Art. 26.91, Subsec. (b).)

26 Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR.
27 If a large employer health benefit plan issuer enters into an

1 agreement with a third-party administrator to provide
2 administrative, marketing, or other services related to offering
3 large employer health benefit plans to large employers in this
4 state, the third-party administrator is subject to this subchapter
5 and Subchapter C. (V.T.I.C. Art. 26.95.)

6 CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

7 SUBCHAPTER A. GENERAL PROVISIONS

8 Sec. 1502.001. APPLICABILITY OF CHAPTER

9 Sec. 1502.002. RULES

10 [Sections 1502.003-1502.050 reserved for expansion]

11 SUBCHAPTER B. CHILDREN'S HEALTH BENEFIT PLAN

12 Sec. 1502.051. CHILDREN'S HEALTH BENEFIT PLAN

13 Sec. 1502.052. MANDATED BENEFIT PROVISIONS INAPPLICABLE

14 Sec. 1502.053. EXEMPTION FROM CERTAIN TAXES

15 CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

16 SUBCHAPTER A. GENERAL PROVISIONS

17 Sec. 1502.001. APPLICABILITY OF CHAPTER. This chapter
18 applies only to the issuer of a health benefit plan that:

19 (1) provides benefits for medical or surgical expenses
20 incurred as a result of a health condition, accident, or sickness,
21 including:

22 (A) an individual, group, blanket, or franchise
23 insurance policy or insurance agreement, a group hospital service
24 contract, or an individual or group evidence of coverage that is
25 offered by:

26 (i) an insurance company;

27 (ii) a group hospital service corporation

operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act or another analogous benefit arrangement; or

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 27.02.)

Sec. 1502.002. RULES. The commissioner may adopt rules to implement this chapter. (V.T.I.C. Art. 27.06.)

[Sections 1502.003-1502.050 reserved for expansion]

SUBCHAPTER B. CHILDREN'S HEALTH BENEFIT PLAN

Sec. 1502.051. CHILDREN'S HEALTH BENEFIT PLAN. A health benefit plan issuer may offer a children's health benefit plan that provides coverage only to children younger than 18 years of age.

1 The issuer may offer the plan only if the commissioner approves the
2 plan's structure and the benefits offered under the plan.
3 (V.T.I.C. Art. 27.03.)

4 Sec. 1502.052. MANDATED BENEFIT PROVISIONS INAPPLICABLE. A
5 children's health benefit plan is not subject to any law that
6 requires coverage or the offer of coverage of a health care service
7 or benefit. (V.T.I.C. Art. 27.04.)

8 Sec. 1502.053. EXEMPTION FROM CERTAIN TAXES. A children's
9 health benefit plan issuer is not subject to the premium tax or the
10 tax on revenues imposed under Chapter 222 with respect to money
11 received for coverage provided under that plan. (V.T.I.C. Art.
12 27.05.)

13 CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

14 Sec. 1503.001. APPLICABILITY OF CHAPTER

15 Sec. 1503.002. EXCEPTION

16 Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS

17 CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

18 Sec. 1503.001. APPLICABILITY OF CHAPTER. This chapter
19 applies only to a health benefit plan that:

20 (1) provides benefits for medical or surgical expenses
21 incurred as a result of a health condition, accident, or sickness,
22 including:

23 (A) an individual, group, blanket, or franchise
24 insurance policy or insurance agreement, a group hospital service
25 contract, or an individual or group evidence of coverage that is
26 offered by:

27 (i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) an analogous benefit arrangement; or

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) another entity that:

(i) is not authorized under this code or another insurance law of this state; and

(ii) contracts directly for health care services on a risk-sharing basis, including a capitation basis. (V.T.I.C. Art. 21.24-2, Sec. 2(a).)

Sec. 1503.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

1 (C) for wages or payments in lieu of wages for a
2 period during which an employee is absent from work because of
3 sickness or injury; or

4 (D) as a supplement to a liability insurance
5 policy;

6 (2) a small employer health benefit plan written under
7 Chapter 1501;

8 (3) a Medicare supplemental policy as defined by
9 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
10 as amended;

11 (4) a workers' compensation insurance policy;

12 (5) medical payment insurance coverage provided under
13 a motor vehicle insurance policy; or

14 (6) a long-term care insurance policy, including a
15 nursing home fixed indemnity policy, unless the commissioner
16 determines that the policy provides benefit coverage so
17 comprehensive that the policy is a health benefit plan as described
18 by Section 1503.001. (V.T.I.C. Art. 21.24-2, Sec. 2(b).)

19 Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS. (a) A health
20 benefit plan may not condition coverage for a child younger than 25
21 years of age on the child's being enrolled at an educational
22 institution.

23 (b) A health benefit plan that requires as a condition of
24 coverage for a child up to 25 years of age that the child be a
25 full-time student at an educational institution must provide the
26 coverage:

27 (1) for the entire academic term during which the

1 child begins as a full-time student and remains enrolled,
2 regardless of whether the number of hours of instruction for which
3 the child is enrolled is reduced to a level that changes the child's
4 academic status to less than that of a full-time student; and

5 (2) continuously until the 10th day of instruction of
6 the subsequent academic term, on which date the health benefit plan
7 may terminate coverage for the child if the child does not return to
8 full-time student status before that date.

9 (c) For purposes of this section, determination of the
10 full-time student status of a child is made in the manner provided
11 by the educational institution at which the child is enrolled.
12 (V.T.I.C. Art. 21.24-2, Sec. 3.)

13 CHAPTER 1504. MEDICAL CHILD SUPPORT

14 SUBCHAPTER A. GENERAL PROVISIONS

15 Sec. 1504.001. DEFINITIONS

16 Sec. 1504.002. RULES

17 Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE
18 TO INJURED PERSON

19 [Sections 1504.004-1504.050 reserved for expansion]

20 SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

21 Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN REQUIRED

22 Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA;

23 COMPARABLE HEALTH COVERAGE REQUIRED

24 Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE
25 FOR CERTAIN CHILDREN

26 Sec. 1504.054. CONTINUATION OR CONVERSION OF
27 COVERAGE

1 Sec. 1504.055. PROCEDURE FOR CLAIMS

2 [Sections 1504.056-1504.100 reserved for expansion]

3 SUBCHAPTER C. PROHIBITED CONDUCT

4 Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN

5 GROUNDS PROHIBITED

6 Sec. 1504.102. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS:

7 DIFFERENT REQUIREMENTS PROHIBITED

8 CHAPTER 1504. MEDICAL CHILD SUPPORT

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Sec. 1504.001. DEFINITIONS. In this chapter:

11 (1) "Child" has the meaning assigned by Section
12 101.003, Family Code.

13 (2) "Child support agency" has the meaning assigned by
14 Section 101.004, Family Code.

15 (3) "Custodial parent" means an individual who:
16 (A) is a managing conservator of a child or a
17 possessory conservator of a child who is a parent of the child; or
18 (B) is a guardian of the person or other
19 custodian of a child and is designated as guardian or custodian by a
20 court or administrative agency of this or another state.

21 (4) "Health benefit plan issuer" means:
22 (A) an insurance company, group hospital service
23 corporation, or health maintenance organization that delivers or
24 issues for delivery an individual, group, blanket, or franchise
25 insurance policy or agreement, a group hospital service contract,
26 or an evidence of coverage that provides benefits for medical or
27 surgical expenses incurred as a result of an accident or sickness;

1 (B) a governmental entity subject to Subchapter
2 D, Chapter 1355, Subchapter C, Chapter 1364, Chapter 1578, or
3 Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5;

4 (C) the issuer of a multiple employer welfare
5 arrangement as defined by Section 846.001; or

6 (D) the issuer of a group health plan as defined
7 by Section 607, Employee Retirement Income Security Act of 1974 (29
8 U.S.C. Section 1167).

9 (5) "Medical assistance" means medical assistance
10 under the state Medicaid program. (V.T.I.C. Art. 3.96-1.)

11 Sec. 1504.002. RULES. (a) The commissioner shall adopt
12 reasonable rules as necessary to implement this chapter and 42
13 U.S.C. Section 1396a(a)(60), including rules that define acts that
14 constitute unfair or deceptive practices under Subchapter I,
15 Chapter 541.

16 (b) The commissioner shall adopt rules that define
17 "comparable health coverage" in a manner that:

18 (1) is consistent with federal law; and

19 (2) complies with the requirements necessary to
20 maintain federal Medicaid funding. (V.T.I.C. Art. 3.96-8, Sec.
21 (c); Art. 3.96-10.)

22 Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE TO
23 INJURED PERSON. A health benefit plan issuer that violates this
24 chapter is subject to the same penalties, and an injured person has
25 the same rights and remedies, as those provided by Subchapter D,
26 Chapter 541. (V.T.I.C. Art. 3.96-9.)

27 [Sections 1504.004-1504.050 reserved for expansion]

SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN REQUIRED.

(a) A health benefit plan issuer shall permit a parent to enroll a child in dependent health coverage offered through the issuer regardless of any enrollment period restriction if the parent is:

(1) eligible for dependent health coverage; and

(2) required by a court order or administrative order to provide health insurance coverage for the child.

(b) A health benefit plan issuer shall enroll a child of a parent described by Subsection (a) in dependent health coverage offered through the issuer if:

(1) the parent does not apply to obtain health coverage for the child through the issuer; and

(2) the child, a custodial parent of the child, or a child support agency having a duty to collect or enforce support for the child applies for the coverage. (V.T.I.C. Art. 3.96-3.)

Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA; COMPARABLE HEALTH COVERAGE REQUIRED. (a) A health benefit plan issuer may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child does not reside in the issuer's service area.

(b) A health benefit plan issuer may not enforce an otherwise applicable provision of the health coverage that would deny, limit, or reduce payment of a claim for a covered child who resides outside the issuer's service area but inside the United States.

(c) For a covered child who resides outside the health

1 benefit plan issuer's service area and whose coverage under a
2 policy or plan is required by a medical support order, the issuer
3 shall provide coverage that is comparable health coverage to that
4 provided to other dependents under the policy or plan.

5 (d) Comparable health coverage may include coverage in
6 which a health benefit plan issuer uses different procedures for
7 service delivery and health care provider reimbursement.
8 Comparable health coverage may not include coverage:

9 (1) that is limited to emergency services only; or

10 (2) for which the issuer charges a higher premium.

11 (V.T.I.C. Art. 3.96-2 (part); Art. 3.96-8, Secs. (a), (b).)

12 Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE FOR
13 CERTAIN CHILDREN. (a) A health benefit plan issuer may not cancel
14 or refuse to renew health coverage provided to a child who is
15 enrolled or entitled to enrollment under this chapter unless
16 satisfactory written evidence is filed with the issuer showing
17 that:

18 (1) the court or administrative order that required
19 the coverage is not in effect; or

20 (2) the child:

21 (A) is enrolled in comparable health coverage; or

22 (B) will be enrolled in comparable health
23 coverage that takes effect not later than the effective date of the
24 cancellation or nonrenewal.

25 (b) For purposes of this section, a child is not enrolled or
26 entitled to enrollment under this chapter if the child's
27 eligibility for health coverage ends because the parent ceases to

1 be eligible for dependent health coverage. (V.T.I.C. Art. 3.96-4.)

2 Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE. (a)
3 If a child's eligibility for dependent health coverage ends because
4 the parent ceases to be eligible for the coverage and the coverage
5 provides for the continuation or conversion of the coverage for the
6 child, the health benefit plan issuer shall notify the custodial
7 parent and the child support agency of the costs and other
8 requirements for continuing or converting the coverage.

9 (b) The health benefit plan issuer shall, on application of
10 a parent of the child, a child support agency, or the child, enroll
11 or continue enrollment of a child whose eligibility for coverage
12 ended under Subsection (a). (V.T.I.C. Art. 3.96-5.)

13 Sec. 1504.055. PROCEDURE FOR CLAIMS. (a) A health benefit
14 plan issuer that provides health coverage to a child through a
15 covered parent of the child shall:

16 (1) provide to each custodial parent of the child or to
17 an adult child documents and other information necessary for the
18 child to obtain benefits under the coverage, including:

19 (A) the name of the issuer;
20 (B) the number of the policy or evidence of
21 coverage;

22 (C) a copy of the policy or evidence of coverage
23 and schedule of benefits;

24 (D) a health coverage membership card;

25 (E) claim forms; and

26 (F) any other document or information necessary
27 to submit a claim in accordance with the issuer's policies and

procedures;

(2) permit a custodial parent, health care provider, state agency that has been assigned medical support rights, or adult child to submit claims for covered services without the approval of the covered parent; and

(3) make payments on covered claims submitted in accordance with this subsection directly to a custodial parent, health care provider, adult child, or state agency making a claim.

(b) A health benefit plan issuer shall provide to a state agency that provides medical assistance to the child or shall provide to a child support agency that enforces medical support on behalf of a child the information necessary to obtain reimbursement of medical services provided to or paid on behalf of the child. (V.T.I.C. Art. 3.96-6, Sec. (b); Art. 3.96-7.)

[Sections 1504.056-1504.100 reserved for expansion]

SUBCHAPTER C. PROHIBITED CONDUCT

Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS PROHIBITED. A health benefit plan issuer may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child:

(1) has a preexisting condition;

(2) was born out of wedlock;

(3) is not claimed as a dependent on the parent's federal income tax return;

(4) does not reside with the parent; or

(5) receives or has applied for medical assistance.

(V.T.I.C. Art. 3.96-2 (part).)

1 (2) a reciprocal or interinsurance exchange;
2 (3) a Lloyd's plan;
3 (4) a fraternal benefit society;
4 (5) a stipulated premium company; and
5 (6) a mutual insurance company, including a statewide
6 mutual assessment company or a local mutual aid association.
7 (V.T.I.C. Art. 3.71, Sec. 1 (part).)

8 Sec. 1505.002. PLANS FOR CERTAIN PERSONS 65 YEARS OF AGE OR
9 OLDER. (a) Two or more health insurers may provide a hospital,
10 surgical, and medical expense insurance plan under a group
11 insurance policy that covers residents of this state who are at
12 least 65 years of age and the spouses of those residents.

13 (b) The participating health insurers may enter into
14 agreements regarding matters within the scope of this chapter,
15 including:

16 (1) premium rates;
17 (2) policy provisions; and
18 (3) sales, administrative, technical, and accounting
19 procedures.

20 (c) Each participating health insurer is subject to
21 regulation under the laws of this state and is severally liable on a
22 group insurance policy issued under this chapter. (V.T.I.C. Art.
23 3.71, Secs. 1 (part), 2 (part).)

24 Sec. 1505.003. APPLICATION AND OTHER EVIDENCE OF INSURANCE
25 FORMS. An application, policy, certificate, or other evidence of
26 insurance form for an insurance plan under this chapter is subject
27 to Chapter 1701. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

1 Sec. 1505.004. EXECUTION OF POLICY. An authorized person
2 may execute an insurance policy subject to this chapter on behalf of
3 the participating health insurers. (V.T.I.C. Art. 3.71, Sec. 1
4 (part).)

5 Sec. 1505.005. USE OF UNINCORPORATED ENTITY. (a) The
6 participating health insurers may issue the group insurance policy
7 in their own names or in the name of an unincorporated association,
8 trust, or other organization formed for the sole purposes of this
9 chapter and evidenced by a written contract executed by the
10 insurers. An unincorporated association, trust, or other
11 organization formed under this subsection may sue and be sued in the
12 name of the association, trust, or organization.

13 (b) A person licensed as a general life, accident, and
14 health agent or as a general property and casualty agent under
15 Chapter 4051 or 4054 may act in the licensed capacity in connection
16 with an insurance policy or a certificate of insurance issued by an
17 unincorporated association, trust, or other organization formed
18 under Subsection (a). The agent is not required to notify the
19 department that the person has been appointed to act for that
20 purpose. (V.T.I.C. Art. 3.71, Secs. 1 (part), 3.)

21 Sec. 1505.006. REQUIRED FILINGS; DEPARTMENT APPROVAL. (a)
22 The participating health insurers shall provide for the filing with
23 the department on behalf of the insurers of:

24 (1) a copy of any contract of association or
25 organization or trust agreement entered into by the insurers under
26 this chapter;

27 (2) the schedule of premium rates to be charged for the

1 insurance coverage; and

2 (3) the plan for operating and marketing the
3 insurance.

4 (b) Except as provided by Subsection (c), a contract,
5 schedule, or plan described by Subsection (a) may not be effective
6 until approved by the commissioner.

7 (c) A contract, schedule, or plan described by Subsection
8 (a) that is not approved or disapproved in a written order of the
9 commissioner on or before the 30th day after the date on which the
10 document is filed with the department is considered approved on the
11 31st day after the date of filing. (V.T.I.C. Art. 3.71, Sec. 2
12 (part).)

13 Sec. 1505.007. EFFECT OF COMMISSIONER DISAPPROVAL. If,
14 after notice and public hearing, the commissioner determines under
15 reasonable assumptions that a premium rate charged for the
16 insurance coverage offered under this chapter or the plan for
17 operating and marketing that insurance is excessive, inadequate, or
18 contrary to the public interest or that any activity or practice
19 performed in connection with the insurance is unfair, unreasonable,
20 or contrary to the public interest, the commissioner shall:

21 (1) enter an order containing the commissioner's
22 determination and disapproving the premium rate or plan or the
23 activity or practice; and

24 (2) require the discontinuance of the premium rate,
25 plan, activity, or practice within a period that is not less than 30
26 days after the date of the commissioner's order containing the
27 determination. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

1 Sec. 1505.008. EXEMPTION FROM PREMIUM TAXES. Each premium
2 received for group insurance coverage authorized by this chapter is
3 exempt from any premium tax imposed by any other law of this state.
4 (V.T.I.C. Art. 3.71, Sec. 4.)

5 Sec. 1505.009. EXEMPTION FROM CERTAIN ANTITRUST
6 REQUIREMENTS. An association, trust, or other organization formed
7 and operated in accordance with this chapter or an insurance
8 business conducted in accordance with this chapter is not
9 considered a combination in restraint of trade, an illegal
10 monopoly, or an attempt to lessen competition or fix prices
11 arbitrarily and does not otherwise violate the antitrust laws of
12 this state. (V.T.I.C. Art. 3.71, Sec. 5.)

13 CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

14 SUBCHAPTER A. GENERAL PROVISIONS

15 Sec. 1506.001. DEFINITIONS

16 Sec. 1506.002. DEFINITION OF HEALTH BENEFIT PLAN

17 Sec. 1506.003. DEFINITION OF DEPENDENT

18 Sec. 1506.004. AUDIT OF POOL

19 Sec. 1506.005. RULES

20 Sec. 1506.006. COMPLAINT PROCEDURES

21 Sec. 1506.007. PROVISION OF INFORMATION ABOUT POOL

22 [Sections 1506.008-1506.050 reserved for expansion]

23 SUBCHAPTER B. BOARD OF DIRECTORS

24 Sec. 1506.051. GOVERNANCE OF POOL; BOARD MEMBERSHIP

25 Sec. 1506.052. PRESIDING OFFICER

26 Sec. 1506.053. TERMS; VACANCY

27 Sec. 1506.054. PER DIEM; REIMBURSEMENT

1 Sec. 1506.055. MEMBER'S IMMUNITY

2 Sec. 1506.056. ADJUSTMENTS

3 Sec. 1506.057. ANNUAL REPORT OF POOL'S ACTIVITIES

4 Sec. 1506.058. ADDITIONAL POWERS AND DUTIES

5 [Sections 1506.059-1506.100 reserved for expansion]

6 SUBCHAPTER C. POWERS AND DUTIES OF POOL

7 Sec. 1506.101. PURPOSES OF POOL

8 Sec. 1506.102. EMPLOYEES; COMMITTEES

9 Sec. 1506.103. PROVIDING COVERAGE

10 Sec. 1506.104. CHARGES, FORMULAS, AND FORMS

11 Sec. 1506.105. PREMIUM RATES

12 Sec. 1506.106. REINSURANCE

13 Sec. 1506.107. CONTRACTS

14 Sec. 1506.108. LEGAL ACTION

15 Sec. 1506.109. COST CONTAINMENT

16 Sec. 1506.110. BORROWING

17 Sec. 1506.111. ADDITIONAL AUTHORITY

18 [Sections 1506.112-1506.150 reserved for expansion]

19 SUBCHAPTER D. POOL COVERAGE AND BENEFITS

20 Sec. 1506.151. MINIMUM POOL COVERAGE

21 Sec. 1506.152. ELIGIBILITY FOR COVERAGE

22 Sec. 1506.153. INELIGIBILITY FOR COVERAGE

23 Sec. 1506.154. LIST OF COVERED CONDITIONS

24 Sec. 1506.155. PREEXISTING CONDITIONS

25 Sec. 1506.156. BENEFIT REDUCTION

26 Sec. 1506.157. RECOVERY OF CERTAIN AMOUNTS

27 Sec. 1506.158. TERMINATION OF POOL COVERAGE

1 Sec. 1506.159. PROHIBITION ON ARRANGEMENT OR ATTEMPTED
2 ARRANGEMENT OF CERTAIN POOL COVERAGE;
3 PENALTY

4 [Sections 1506.160-1506.200 reserved for expansion]

5 SUBCHAPTER E. OPERATION OF POOL

6 Sec. 1506.201. PLAN OF OPERATION

7 Sec. 1506.202. POOL ADMINISTRATOR

8 Sec. 1506.203. ADMINISTRATOR'S TERM; SUCCEEDING TERM

9 Sec. 1506.204. ADMINISTRATOR'S FUNCTIONS

10 Sec. 1506.205. PAYMENTS TO ADMINISTRATOR

11 [Sections 1506.206-1506.250 reserved for expansion]

12 SUBCHAPTER F. ASSESSMENTS FOR OPERATION OF POOL

13 Sec. 1506.251. INTERIM ASSESSMENTS

14 Sec. 1506.252. DETERMINATION OF NET LOSS

15 Sec. 1506.253. ASSESSMENTS TO COVER NET LOSSES

16 Sec. 1506.254. ASSESSMENT DUE DATE; INTEREST

17 Sec. 1506.255. ABATEMENT OR DEFERMENT OF ASSESSMENT

18 Sec. 1506.256. USE OF EXCESS FROM ASSESSMENTS

19 Sec. 1506.257. COLLECTION OF ASSESSMENTS

20 Sec. 1506.258. PROCEDURES, CRITERIA, AND FORMS

21 CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Sec. 1506.001. DEFINITIONS. In this chapter:

24 (1) "Board" means the board of directors of the pool.

25 (2) "Health benefit arrangement" means a plan,
26 program, contract, or other arrangement through which an employer
27 provides health care services, other than health care services

covered through a health benefit plan issuer, to the employer's officers, employees, or other personnel.

(3) "Health benefit plan issuer" means an entity that provides health benefit plan coverage in this state, including stop-loss or excess loss insurance. The term includes:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization;

(F) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(G) an eligible surplus lines insurer operating under Chapter 981;

(H) an insurer providing stop-loss or excess loss insurance to physicians, health care providers, or hospitals or to any benefit arrangements to the extent permitted by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); and

(I) any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(4) "Health maintenance organization" means an entity that holds a certificate of authority to operate under Chapter 843.

(5) "Hospital" means a hospital for which a license is

1 issued under Chapter 241, Health and Safety Code, or that is owned
2 or operated by the federal or state government.

3 (6) "Physician" means a person licensed to practice
4 medicine in this state under Subtitle B, Title 3, Occupations Code.

5 (7) "Pool" means the Texas Health Insurance Risk Pool.
6 (V.T.I.C. Art. 3.77, Secs. 2(2), (8), (9), (11), (12), (14), (16).)

7 Sec. 1506.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In
8 this chapter, "health benefit plan" means an individual or group
9 health benefit plan and includes:

10 (1) a hospital or medical expense incurred policy;

11 (2) coverage of medical or health care services
12 offered by:

13 (A) a group hospital service corporation
14 operating under Chapter 842;

15 (B) a fraternal benefit society operating under
16 Chapter 885;

17 (C) a stipulated premium company operating under
18 Chapter 884;

19 (D) a health maintenance organization;

20 (E) a multiple employer welfare arrangement
21 subject to Chapter 846; or

22 (F) an approved nonprofit health corporation
23 that holds a certificate of authority under Chapter 844; and

24 (3) any other health care plan or arrangement that
25 pays for or furnishes medical or health care services by insurance
26 or otherwise.

27 (b) In this chapter, "health benefit plan" does not include:

- 1 (1) short-term insurance;
- 2 (2) accident insurance;
- 3 (3) a plan providing coverage only for dental or
- 4 vision care;
- 5 (4) fixed indemnity insurance, including hospital
- 6 indemnity insurance;
- 7 (5) credit insurance;
- 8 (6) long-term care insurance;
- 9 (7) disability income insurance;
- 10 (8) other limited benefit coverage, including
- 11 specified disease coverage;
- 12 (9) coverage issued as a supplement to liability
- 13 insurance;
- 14 (10) insurance arising out of a workers' compensation
- 15 or similar law;
- 16 (11) automobile medical payment insurance; or
- 17 (12) insurance coverage under which benefits are
- 18 payable with or without regard to fault and that is statutorily
- 19 required to be contained in a liability insurance policy or
- 20 equivalent self-insurance. (V.T.I.C. Art. 3.77, Sec. 2(7).)

21 Sec. 1506.003. DEFINITION OF DEPENDENT. In this chapter,

22 "dependent" means:

- 23 (1) a resident spouse or unmarried child younger than
- 24 25 years of age; or
- 25 (2) a child who is:
- 26 (A) a full-time student younger than 25 years of
- 27 age who is financially dependent on the parent;

1 (B) 18 years of age or older and is an individual
2 for whom a person may be obligated to pay child support; or

3 (C) disabled and dependent on the parent
4 regardless of the age of the child. (V.T.I.C. Art. 3.77, Sec.
5 2(5).)

6 Sec. 1506.004. AUDIT OF POOL. (a) Annually, the state
7 auditor shall conduct a special audit of the pool under Chapter 321,
8 Government Code. The special audit must include a financial audit
9 and an economy and efficiency audit.

10 (b) The state auditor shall report the cost of each audit
11 conducted under this section to the board and the comptroller. The
12 board shall remit that amount to the comptroller. (V.T.I.C. Art.
13 3.77, Sec. 15.)

14 Sec. 1506.005. RULES. The commissioner may adopt rules
15 necessary and proper to implement this chapter. (V.T.I.C. Art.
16 3.77, Sec. 8 (part).)

17 Sec. 1506.006. COMPLAINT PROCEDURES. (a) An applicant for
18 or participant in coverage from the pool is entitled to have
19 complaints against the pool reviewed by a grievance committee
20 appointed by the board.

21 (b) The grievance committee shall report to the board after
22 completion of the review of each complaint.

23 (c) The board shall retain each written complaint
24 concerning the pool at least until the third anniversary of the date
25 the pool received the complaint. (V.T.I.C. Art. 3.77, Sec. 14.)

26 Sec. 1506.007. PROVISION OF INFORMATION ABOUT POOL. (a) A
27 health benefit plan issuer may provide to its insureds and

1 enrollees a notice relating to the existence of the pool that
2 contains the address from which an insured or enrollee may obtain
3 information about the coverage offered by the pool, the eligibility
4 for and cost of the coverage, and other information that allows an
5 insured or enrollee to compare the issuer's health benefit plan
6 coverage provided to the insured or enrollee with the coverage
7 offered by the pool.

8 (b) A health benefit plan issuer providing notice under this
9 section shall provide the notice as prescribed by the commissioner.

10 (c) A health benefit plan issuer does not incur any
11 liability solely for providing notice under this section.
12 (V.T.I.C. Art. 3.77, Secs. 2(1), 16(a), (b) (part).)

13 [Sections 1506.008-1506.050 reserved for expansion]

14 SUBCHAPTER B. BOARD OF DIRECTORS

15 Sec. 1506.051. GOVERNANCE OF POOL; BOARD MEMBERSHIP. (a)
16 The pool is governed by a board of directors.

17 (b) The board consists of nine members appointed by the
18 commissioner as follows:

19 (1) at least two, but not more than four, members must
20 be individuals who are affiliated with a health benefit plan issuer
21 authorized to write health benefit plans in this state;

22 (2) at least two of the members must be individuals or
23 the parents of individuals who are covered by the pool or are
24 reasonably expected to qualify for coverage by the pool; and

25 (3) the other members of the board may be selected from
26 individuals such as:

27 (A) a physician licensed to practice in this

1 state by the Texas State Board of Medical Examiners;

2 (B) a hospital administrator;

3 (C) an advanced nurse practitioner; or

4 (D) a representative of the public who is not:

5 (i) employed by or affiliated with an
6 insurance company or insurance plan, group hospital service
7 corporation, or health maintenance organization; or

8 (ii) licensed as, employed by, or
9 affiliated with a physician, hospital, or other health care
10 provider.

11 (c) For purposes of Subsection (b), an individual who is
12 required to register under Chapter 305, Government Code, because of
13 the individual's activities with respect to health benefit
14 plan-related matters is affiliated with a health benefit plan
15 issuer.

16 (d) An individual is not disqualified under Subsection
17 (b)(3)(D)(i) from representing the public if the individual's only
18 affiliation with an insurance company or insurance plan, group
19 hospital service corporation, or health maintenance organization
20 is as an insured or as an individual who has coverage through a plan
21 provided by the corporation or organization. (V.T.I.C. Art. 3.77,
22 Secs. 4(a), (b) (part), (c), (d).)

23 Sec. 1506.052. PRESIDING OFFICER. The commissioner shall
24 designate one member of the board to serve as presiding officer at
25 the pleasure of the commissioner. (V.T.I.C. Art. 3.77, Sec. 4(g).)

26 Sec. 1506.053. TERMS; VACANCY. (a) Members of the board
27 serve staggered six-year terms.

1 (b) The commissioner shall fill a vacancy on the board by
2 appointing, for the unexpired term, an individual who has the
3 appropriate qualifications to fill that position. (V.T.I.C. Art.
4 3.77, Secs. 4(b) (part), (e).)

5 Sec. 1506.054. PER DIEM; REIMBURSEMENT. A member of the
6 board is entitled to:

7 (1) a per diem in the amount provided by the General
8 Appropriations Act for state officials for each day the member
9 performs duties as a board member; and

10 (2) reimbursement of expenses incurred while
11 performing duties as a board member in the amount provided by the
12 General Appropriations Act for state officials. (V.T.I.C. Art.
13 3.77, Sec. 4(f).)

14 Sec. 1506.055. MEMBER'S IMMUNITY. (a) A member of the
15 board is not liable for an act or omission made in good faith in the
16 performance of powers and duties under this chapter.

17 (b) A cause of action does not arise against a member of the
18 board for an act or omission described by Subsection (a). (V.T.I.C.
19 Art. 3.77, Sec. 4(h).)

20 Sec. 1506.056. ADJUSTMENTS. (a) The board may adjust
21 deductibles, the amounts of stop-loss coverage, and the periods
22 governing preexisting conditions under Section 1506.155 to
23 preserve the financial integrity of the pool.

24 (b) Not later than the 30th day after the date the board
25 makes an adjustment under this section, the board shall submit to
26 the commissioner a written report containing a description of and
27 the reasons for the adjustment. (V.T.I.C. Art. 3.77, Sec. 11(c).)

1 Sec. 1506.057. ANNUAL REPORT OF POOL'S ACTIVITIES. (a) Not
2 later than June 1 of each year, the board shall submit a report to
3 the governor, the lieutenant governor, the speaker of the house of
4 representatives, and the commissioner.

5 (b) The report must summarize the activities of the pool in
6 the calendar year preceding the year in which the report is
7 submitted and must include information relating to net written and
8 earned premiums, plan enrollment, administration expenses, and
9 paid and incurred losses. (V.T.I.C. Art. 3.77, Sec. 6(d).)

10 Sec. 1506.058. ADDITIONAL POWERS AND DUTIES. The
11 commissioner by rule may establish powers and duties of the board in
12 addition to those provided by this chapter. (V.T.I.C. Art. 3.77,
13 Sec. 8 (part).)

14 [Sections 1506.059-1506.100 reserved for expansion]

15 SUBCHAPTER C. POWERS AND DUTIES OF POOL

16 Sec. 1506.101. PURPOSES OF POOL. (a) The purposes of the
17 pool are to:

18 (1) provide for access to quality health care at
19 minimum cost to the public;

20 (2) relieve the insurable population of the disruptive
21 cost of sharing coverage; and

22 (3) maximize reliance on strategies of managed care
23 proven by the private sector.

24 (b) The pool is not intended to diminish the availability of
25 traditional health care coverage to consumers who are eligible for
26 that coverage. (V.T.I.C. Art. 3.77, Secs. 1(c), (d).)

27 Sec. 1506.102. EMPLOYEES; COMMITTEES. (a) The pool may

1 employ and set the compensation of any persons necessary to assist
2 the pool in carrying out its responsibilities and functions.

3 (b) The pool may appoint appropriate legal, actuarial, and
4 other committees necessary to provide technical assistance in
5 operating the pool and performing any of the functions of the pool.
6 (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

7 Sec. 1506.103. PROVIDING COVERAGE. (a) The pool may
8 provide health benefit coverage to an individual who is eligible
9 for that coverage under this chapter.

10 (b) The pool may issue health benefit coverage subject to
11 this chapter and the pool's plan of operation under Section
12 1506.201.

13 (c) The pool may issue additional types of health benefit
14 coverage to provide optional coverages that comply with applicable
15 provisions of state and federal law, including a Medicare
16 supplement benefit plan. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

17 Sec. 1506.104. CHARGES, FORMULAS, AND FORMS. (a) The pool
18 may establish appropriate rates, rate schedules, rate adjustments,
19 expense allowances, agents' referral fees, and claim reserve
20 formulas and perform actuarial functions appropriate to the
21 operation of the pool.

22 (b) The pool may adopt policy forms, endorsements, and
23 riders and applications for coverage. (V.T.I.C. Art. 3.77, Sec.
24 6(b) (part).)

25 Sec. 1506.105. PREMIUM RATES. (a) The pool may not charge
26 premium rates that are unreasonable in relation to the benefits
27 provided, the risk experience, and the reasonable expenses of

1 providing the coverage.

2 (b) Separate schedules of premium rates based on age, sex,
3 and geographic location may apply for individual risks.

4 (c) Premium rates and premium rate schedules may be adjusted
5 for appropriate risk factors, including age and variation in claim
6 costs. The pool may consider appropriate risk factors in
7 accordance with established actuarial and underwriting practices.

8 (d) The pool shall establish the standard risk rate. In
9 establishing the rate, the pool shall use reasonable actuarial
10 techniques and consider the premium rates charged by other health
11 benefit plan issuers offering health benefit coverage to
12 individuals. The rate must reflect anticipated experience and
13 expenses for health benefit coverage.

14 (e) Initial pool premium rates may not be less than 125
15 percent or greater than 150 percent of rates established as
16 applicable for individual standard rates. Subsequent premium rates
17 shall be established to provide fully for all of the expected costs
18 of claims, including recovery of prior losses, expenses of
19 operation, investment income from claim reserves, and any other
20 cost factors, subject to the limitations described in this
21 subsection. In no event may pool premium rates exceed 200 percent
22 of rates applicable to individual standard risks.

23 (f) The pool shall submit each rate and rate schedule to the
24 commissioner for approval. The pool may not use a rate or rate
25 schedule before the rate or schedule is approved by the
26 commissioner. In evaluating a rate or rate schedule of the pool,
27 the commissioner shall consider the factors provided by this

1 section. (V.T.I.C. Art. 3.77, Sec. 9.)

2 Sec. 1506.106. REINSURANCE. The pool may provide for
3 reinsurance on a facultative or treaty basis or on both facultative
4 and treaty bases. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

5 Sec. 1506.107. CONTRACTS. (a) The pool may enter into a
6 contract that is necessary to carry out this chapter, including,
7 with the approval of the commissioner, a contract with:

8 (1) a similar pool in another state for the joint
9 performance of common administrative functions; or

10 (2) another organization for the performance of
11 administrative functions.

12 (b) The pool may contract for stop-loss insurance for risks
13 incurred by the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

14 Sec. 1506.108. LEGAL ACTION. (a) The pool may sue or be
15 sued.

16 (b) The pool may take any legal action necessary to:

17 (1) avoid payment of improper claims against the pool
18 or the coverage provided by or through the pool; or

19 (2) recover or collect amounts due the pool,
20 including:

21 (A) assessments due the pool;

22 (B) amounts erroneously or improperly paid by the
23 pool; and

24 (C) amounts paid by the pool as a mistake of fact
25 or law. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

26 Sec. 1506.109. COST CONTAINMENT. (a) The pool may provide
27 for and use cost containment measures and requirements, including

1 preadmission screening, the requirement of a second surgical
2 opinion, concurrent utilization review subject to Article 21.58A,
3 and individual case management, to make the coverage offered by the
4 pool more cost-effective.

5 (b) The pool may design, use, contract for, or otherwise
6 arrange for the delivery of cost-effective health care services,
7 including establishing or contracting with preferred provider
8 organizations and health maintenance organizations. (V.T.I.C.
9 Art. 3.77, Secs. 2(1), 6(b) (part).)

10 Sec. 1506.110. BORROWING. The pool may borrow money as
11 necessary to implement the purposes of the pool. (V.T.I.C. Art.
12 3.77, Sec. 6(b) (part).)

13 Sec. 1506.111. ADDITIONAL AUTHORITY. In addition to the
14 other powers granted to the pool under this chapter, the pool may
15 exercise any of the authority that a health benefit plan issuer
16 authorized to write health benefit plans in this state may exercise
17 under the law of this state. (V.T.I.C. Art. 3.77, Sec. 6(a).)

18 [Sections 1506.112-1506.150 reserved for expansion]

19 SUBCHAPTER D. POOL COVERAGE AND BENEFITS

20 Sec. 1506.151. MINIMUM POOL COVERAGE. (a) The pool shall
21 offer coverage consistent with major medical expense coverage to
22 each eligible individual who is not eligible for Medicare.

23 (b) The board, with the approval of the commissioner, shall
24 establish:

- 25 (1) the coverages to be provided by the pool;
26 (2) the applicable schedules of benefits; and
27 (3) any exclusions to coverage and other limitations.

1 (c) The benefits provisions of the pool's coverage must
2 include:

- 3 (1) all required or applicable definitions;
4 (2) a description of covered services required under
5 the pool;
6 (3) a list of any exclusions or limitations to
7 coverage; and
8 (4) the deductibles, coinsurance options, and
9 copayment options that are required or permitted. (V.T.I.C. Art.
10 3.77, Secs. 11(a), (b).)

11 Sec. 1506.152. ELIGIBILITY FOR COVERAGE. (a) An
12 individual who is a legally domiciled resident of this state is
13 eligible for coverage from the pool if the individual:

14 (1) provides to the pool evidence that the individual
15 maintained health benefit plan coverage for the preceding 18 months
16 with no gap in coverage longer than 63 days and with the most recent
17 coverage being provided through an employer-sponsored plan, church
18 plan, or government plan;

19 (2) provides to the pool evidence that the individual
20 maintained health benefit plan coverage under another state's
21 qualified Health Insurance Portability and Accountability Act
22 health program that was terminated because the individual did not
23 reside in that state and submits an application for pool coverage
24 not later than the 63rd day after the date the coverage described by
25 this subdivision was terminated; or

26 (3) has been a legally domiciled resident of this
27 state for the preceding 30 days, is a citizen of the United States

1 or has been a permanent resident of the United States for at least
2 three continuous years, and provides to the pool:

3 (A) a notice of rejection of, or refusal to
4 issue, substantially similar individual health benefit plan
5 coverage from a health benefit plan issuer, other than an insurer
6 that offers only stop-loss, excess loss, or reinsurance coverage,
7 if the rejection or refusal was for health reasons;

8 (B) certification from an agent or salaried
9 representative of a health benefit plan issuer that states that the
10 agent or salaried representative cannot obtain substantially
11 similar individual coverage for the individual from any health
12 benefit plan issuer that the agent or salaried representative
13 represents because, under the underwriting guidelines of the health
14 benefit plan issuer, the individual will be denied coverage as a
15 result of a medical condition of the individual;

16 (C) an offer to issue substantially similar
17 individual coverage only with conditional riders;

18 (D) a notice of refusal by a health benefit plan
19 issuer to issue substantially similar individual coverage except at
20 a rate exceeding the pool rate; or

21 (E) a diagnosis of the individual with one of the
22 medical or health conditions on the list adopted under Section
23 1506.154.

24 (b) Each dependent of an individual who is eligible for
25 coverage from the pool is also eligible for coverage from the pool.

26 (c) If an individual who obtains coverage from the pool
27 under Subsection (a) is a child, each parent, grandparent, brother,

1 sister, or child of that individual who resides with that
2 individual is also eligible for coverage from the pool.

3 (d) The board shall develop a form to be used for
4 certification under Subsection (a)(3)(B). Before it may be used,
5 the form must be approved by the commissioner. (V.T.I.C. Art. 3.77,
6 Secs. 2(6), (17), 10(a), (b), (c).)

7 Sec. 1506.153. INELIGIBILITY FOR COVERAGE.
8 Notwithstanding Section 1506.152, an individual is not eligible for
9 coverage from the pool if:

10 (1) on the date pool coverage is to take effect, the
11 individual has health benefit plan coverage from a health benefit
12 plan issuer or health benefit arrangement in effect;

13 (2) at the time the individual applies to the pool, the
14 individual is eligible for other health care benefits, including
15 benefits from the continuation of coverage under Title X,
16 Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C.
17 Section 1161 et seq.), as amended (COBRA), other than:

18 (A) coverage, including COBRA or other
19 continuation coverage or conversion coverage, maintained for any
20 preexisting condition waiting period under a pool policy;

21 (B) employer group coverage conditioned by a
22 limitation of the kind described by Section 1506.152(a)(3)(A) or
23 (C); or

24 (C) individual coverage conditioned by a
25 limitation described by Section 1506.152(a)(3)(C) or (D);

26 (3) within 12 months before the date the individual
27 applies to the pool, the individual terminated coverage in the

1 pool, unless the individual demonstrates a good faith reason for
2 the termination;

3 (4) the individual is confined in a county jail or
4 imprisoned in a state prison;

5 (5) any of the individual's premiums are paid for or
6 reimbursed under a government-sponsored program or by a government
7 agency or health care provider, other than as an otherwise
8 qualifying full-time employee of a government agency or health care
9 provider or as a dependent of such an employee;

10 (6) the individual's prior coverage with the pool was
11 terminated:

12 (A) during the 12-month period preceding the date
13 of application for nonpayment of premiums; or

14 (B) for fraud; or

15 (7) the individual is eligible for health benefit plan
16 coverage provided in connection with a policy, plan, or program
17 paid for or sponsored by an employer, even though the employer
18 coverage is declined. (V.T.I.C. Art. 3.77, Secs. 10(e), (h)
19 (part).)

20 Sec. 1506.154. LIST OF COVERED CONDITIONS. (a) The board
21 shall adopt a list of medical or health conditions for which an
22 individual is eligible for pool coverage under Section
23 1506.152(a)(3)(E) without applying for health benefit plan
24 coverage.

25 (b) The board may amend the list as appropriate. (V.T.I.C.
26 Art. 3.77, Sec. 6(c) (part).)

27 Sec. 1506.155. PREEXISTING CONDITIONS. (a) Except as

1 provided by this section and Section 1506.056, pool coverage
2 excludes charges or expenses incurred before the first anniversary
3 of the effective date of coverage with regard to any condition for
4 which medical advice, care, or treatment was recommended or
5 received during the six-month period preceding the effective date
6 of coverage.

7 (b) The exclusion provided by Subsection (a) does not apply
8 to an individual who:

9 (1) was continuously covered for a period of at least
10 12 months, excluding any waiting period, by health benefit plan
11 coverage that terminated not earlier than the 63rd day before the
12 effective date of coverage under the pool; and

13 (2) applied for pool coverage not later than the 63rd
14 day after the date the health benefit plan coverage described by
15 Subdivision (1) terminated.

16 (c) If an individual was covered by health benefit plan
17 coverage that was in effect at any time during the 12-month period
18 preceding the effective date of the individual's coverage under the
19 pool, the pool shall subtract from the exclusion period required
20 under Subsection (a) the period that the individual was covered
21 under that health benefit plan and any waiting period that applied
22 before that health benefit plan coverage became effective.

23 (V.T.I.C. Art. 3.77, Sec. 12.)

24 Sec. 1506.156. BENEFIT REDUCTION. The pool shall reduce
25 benefits otherwise payable under pool coverage by:

26 (1) the total amount paid or payable through any other
27 health benefit plan or health benefit arrangement; and

1 (2) the total amount of hospital or medical expense
2 benefits paid or payable under:

3 (A) workers' compensation coverage;

4 (B) automobile insurance, regardless of whether
5 provided on the basis of fault or no fault; or

6 (C) a state or federal law or program. (V.T.I.C.
7 Art. 3.77, Sec. 11(d).)

8 Sec. 1506.157. RECOVERY OF CERTAIN AMOUNTS. (a) The pool
9 has a cause of action against an eligible individual for the
10 recovery of the amount of benefits paid that are not for covered
11 expenses.

12 (b) Benefits due from the pool may be reduced or refused as
13 an offset against an amount recoverable under this section.
14 (V.T.I.C. Art. 3.77, Sec. 11(e).)

15 Sec. 1506.158. TERMINATION OF POOL COVERAGE. (a) An
16 individual's pool coverage ends:

17 (1) on the date the individual ceases to be a legally
18 domiciled resident of this state, unless the individual:

19 (A) is a student younger than 25 years of age and
20 is financially dependent on the parent;

21 (B) is a child for whom an individual may be
22 obligated to pay child support; or

23 (C) is a child who is disabled and dependent on
24 the parent, regardless of the age of the child;

25 (2) on the date the individual requests coverage to
26 end;

27 (3) on the date the individual covered by the pool

1 dies;

2 (4) on the date state law requires cancellation of the
3 coverage;

4 (5) at the option of the pool, on the 31st day after
5 the date the pool sends to the individual any inquiry concerning the
6 individual's eligibility, including an inquiry concerning the
7 individual's residence, to which the individual does not reply;

8 (6) on the 31st day after the date a premium payment
9 for pool coverage becomes due if the payment is not made before that
10 day; or

11 (7) at the time the individual ceases to meet the
12 eligibility requirements for coverage.

13 (b) Notwithstanding Subsection (a), the coverage of an
14 individual who ceases to meet the eligibility requirements for
15 coverage terminates on the earlier of:

16 (1) the first premium due date after the date the pool
17 determines the individual does not meet the eligibility
18 requirements; or

19 (2) the first day of the first month after the month in
20 which the pool determines the individual does not meet the
21 eligibility requirements.

22 (c) The pool has the sole discretion to determine that an
23 individual does not meet the eligibility requirements for coverage.

24 (d) An individual may maintain pool coverage for the period
25 the individual is satisfying a preexisting waiting period under
26 another health benefit plan or health benefit arrangement intended
27 to replace the pool coverage. (V.T.I.C. Art. 3.77, Secs. 10(d),

1 (f), (g).)

2 Sec. 1506.159. PROHIBITION ON ARRANGEMENT OR ATTEMPTED
3 ARRANGEMENT OF CERTAIN POOL COVERAGE; PENALTY. (a) A health
4 benefit plan issuer, agent, third-party administrator, or other
5 person authorized or licensed under this code may not arrange or
6 assist in, or attempt to arrange or assist in, the application for
7 coverage from or placement in the pool of an individual who is not
8 eligible under Section 1506.153(7) for coverage from the pool for
9 the purpose of separating the person from health benefit plan
10 coverage offered or provided in connection with employment that
11 would be available to the person as an employee or a dependent of an
12 employee.

13 (b) A violation of this section is an unfair method of
14 competition and an unfair or deceptive act or practice under
15 Chapter 541. (V.T.I.C. Art. 3.77, Sec. 10(h) (part).)

16 [Sections 1506.160-1506.200 reserved for expansion]

17 SUBCHAPTER E. OPERATION OF POOL

18 Sec. 1506.201. PLAN OF OPERATION. (a) Operation and
19 management of the pool is governed by a plan of operation. The plan
20 of operation includes the articles, bylaws, and operating rules of
21 the pool that are adopted by the board.

22 (b) The plan of operation must ensure the fair, reasonable,
23 and equitable administration of the pool.

24 (c) In addition to complying with the other requirements of
25 this chapter, the plan of operation must include procedures for:

26 (1) operation of the pool;

27 (2) selection of an administrator as provided by

1 Section 1506.202;

2 (3) creation of a fund, under management of the board,
3 for administrative expenses;

4 (4) handling, accounting, and auditing of money and
5 other assets of the pool;

6 (5) development and implementation of a program to:

7 (A) publicize the existence of the pool, the
8 eligibility requirements for coverage under the pool, and
9 enrollment procedures; and

10 (B) foster public awareness of the pool;

11 (6) creation of a grievance committee to review
12 complaints presented by applicants for coverage from the pool and
13 individuals who are covered by the pool; and

14 (7) other matters as may be necessary and proper for
15 the execution of the board's powers, duties, and obligations under
16 this chapter.

17 (d) The board shall amend the plan of operation as necessary
18 to carry out this chapter. An amendment to the plan of operation
19 must be approved by the commissioner before it becomes a part of the
20 plan. (V.T.I.C. Art. 3.77, Secs. 2(15), 5(a) (part), (b), (f).)

21 Sec. 1506.202. POOL ADMINISTRATOR. (a) The board may
22 select one or more health benefit plan issuers or a third-party
23 administrator authorized by the department to administer the pool.
24 The selection must be made under a competitive bidding process in
25 accordance with the plan of operation.

26 (b) The board shall establish criteria for evaluating the
27 bids submitted under this section. The criteria must include:

1 (1) the bidder's proven ability to handle individual
2 health benefit plans;

3 (2) the bidder's efficiency of claims paying
4 procedures;

5 (3) an estimate of total charges for administering the
6 pool;

7 (4) the bidder's ability to administer the pool in a
8 cost-efficient manner; and

9 (5) the bidder's financial condition and stability.
10 (V.T.I.C. Art. 3.77, Secs. 7(a), (b).)

11 Sec. 1506.203. ADMINISTRATOR'S TERM; SUCCEEDING TERM. (a)
12 A person selected as a pool administrator serves in that capacity
13 for a three-year term beginning on the date the board issues its
14 order making the selection.

15 (b) Not later than one year before the expiration of a pool
16 administrator's term, the board shall invite all health benefit
17 plan issuers, including the pool administrator, to submit bids to
18 serve as a pool administrator for the succeeding administration
19 period. The selection of the succeeding pool administrator must be
20 made not later than the sixth calendar month preceding the month in
21 which the pool administrator's term expires. (V.T.I.C. Art. 3.77,
22 Secs. 7(c), (d).)

23 Sec. 1506.204. ADMINISTRATOR'S FUNCTIONS. (a) A pool
24 administrator shall perform the functions relating to the pool that
25 are assigned to the administrator.

26 (b) The assigned functions may include:

27 (1) performing eligibility and administrative claims

1 payment functions for the pool;

2 (2) establishing a billing procedure for collection of
3 premiums from individuals covered by the pool;

4 (3) performing functions necessary to ensure timely
5 payment of benefits to individuals covered by the pool, including:

6 (A) providing information relating to the proper
7 manner of submitting a claim for benefits to the pool and
8 distributing claim forms; and

9 (B) evaluating the eligibility of each claim for
10 payment by the pool;

11 (4) submitting regular reports to the board relating
12 to the operation of the pool; and

13 (5) determining after each calendar year the net
14 written and earned premiums, expenses of administration, and paid
15 and incurred losses of the pool for that calendar year and reporting
16 that information to the board and the commissioner.

17 (c) The board shall determine the form, content, and time of
18 submission of the reports required under Subsection (b)(4).

19 (d) The commissioner shall prescribe the forms to be used to
20 report the information under Subsection (b)(5).

21 (e) The board shall determine the times at which a pool
22 administrator is to perform the billing functions for the pool.
23 (V.T.I.C. Art. 3.77, Secs. 7(e), (g), (h).)

24 Sec. 1506.205. PAYMENTS TO ADMINISTRATOR. (a) The pool
25 shall pay a pool administrator for the administrator's expenses
26 incurred in performing duties and functions as provided by the plan
27 of operation.

1 (b) Except as provided by Subsection (c), the total amount
2 of administrative costs and fees paid in a calendar year to all pool
3 administrators may not exceed 12.5 percent of the gross premium
4 receipts of the pool for the calendar year.

5 (c) The commissioner may approve payment of a higher amount,
6 not to exceed 15 percent of the gross premium receipts of the pool
7 for the calendar year, if the commissioner determines that the
8 higher amount is necessary to pay the administrative costs and fees
9 of the pool. (V.T.I.C. Art. 3.77, Sec. 7(f).)

10 [Sections 1506.206-1506.250 reserved for expansion]

11 SUBCHAPTER F. ASSESSMENTS FOR OPERATION OF POOL

12 Sec. 1506.251. INTERIM ASSESSMENTS. (a) The board may
13 assess health benefit plan issuers, including making advance
14 interim assessments, as reasonable and necessary for the pool's
15 organizational and interim operating expenses.

16 (b) The board shall credit an interim assessment as an
17 offset against any regular assessment that is due after the end of
18 the fiscal year. (V.T.I.C. Art. 3.77, Sec. 13(a).)

19 Sec. 1506.252. DETERMINATION OF NET LOSS. (a) After the
20 end of each fiscal year, the board shall determine for the preceding
21 calendar year any net loss of the pool, including administrative
22 expenses and incurred losses, and report the net loss to the
23 commissioner.

24 (b) In determining the net loss, the board shall take into
25 account investment income and other appropriate gains and losses.
26 (V.T.I.C. Art. 3.77, Sec. 13(c) (part).)

27 Sec. 1506.253. ASSESSMENTS TO COVER NET LOSSES. (a) The

1 board shall recover any net loss of the pool by assessing each
2 health benefit plan issuer an amount determined annually by the
3 board based on information in annual statements and other reports
4 required by and filed with the board.

5 (b) The amount of a health benefit plan issuer's assessment
6 is computed by multiplying the total amount required to be assessed
7 against all health benefit plan issuers by a number computed by
8 dividing:

9 (1) the gross premiums collected by the issuer for
10 health benefit plans in this state during the preceding calendar
11 year; by

12 (2) the gross premiums collected by all issuers for
13 health benefit plans in this state during the preceding calendar
14 year.

15 (c) For purposes of Subsection (b), gross health benefit
16 plan premiums do not include Medicare supplement benefit plan
17 premiums subject to Chapter 1652 or small employer health benefit
18 plan premiums subject to Subchapters A-H, Chapter 1501. (V.T.I.C.
19 Art. 3.77, Secs. 13(c) (part), (d) (part).)

20 Sec. 1506.254. ASSESSMENT DUE DATE; INTEREST. (a) An
21 assessment is due on the date specified by the board that is not
22 earlier than the 30th day after the date written notice of the
23 assessment is transmitted to the health benefit plan issuer.

24 (b) Interest accrues on the unpaid amount of an assessment
25 at a rate equal to the prime lending rate, as published in the most
26 recent issue of the Wall Street Journal and determined as of the
27 date the assessment becomes delinquent, plus three percent.

1 (V.T.I.C. Art. 3.77, Sec. 13(d) (part).)

2 Sec. 1506.255. ABATEMENT OR DEFERMENT OF ASSESSMENT. (a) A
3 health benefit plan issuer may petition the commissioner for an
4 abatement or deferment of all or part of an assessment imposed by
5 the board. The commissioner may abate or defer all or part of the
6 assessment if the commissioner determines that payment of the
7 assessment would endanger the ability of the health benefit plan
8 issuer to fulfill its contractual obligations.

9 (b) If all or part of an assessment against a health benefit
10 plan issuer is abated or deferred, the amount of the abatement or
11 deferment shall be assessed against the other health benefit plan
12 issuers in a manner consistent with the method for computing
13 assessments under this subchapter.

14 (c) A health benefit plan issuer receiving an abatement or
15 deferment under this section remains liable to the pool for the
16 deficiency. (V.T.I.C. Art. 3.77, Sec. 13(e).)

17 Sec. 1506.256. USE OF EXCESS FROM ASSESSMENTS. (a) In this
18 section, "future losses" includes reserves for claims incurred but
19 not reported.

20 (b) If the total amount of the assessments exceeds the
21 pool's actual losses and administrative expenses, the board shall
22 deposit the excess in an interest-bearing account and shall use
23 money in that account to offset future losses or to reduce future
24 assessments. (V.T.I.C. Art. 3.77, Sec. 13(b).)

25 Sec. 1506.257. COLLECTION OF ASSESSMENTS. The pool may
26 recover or collect assessments made under this subchapter.
27 (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

1 Sec. 1506.258. PROCEDURES, CRITERIA, AND FORMS. The
2 commissioner by rule shall provide the procedures, criteria, and
3 forms necessary to implement, collect, and deposit assessments
4 under this subchapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

5 SECTION 4. SUBTITLE I, TITLE 8, INSURANCE CODE. Title 8,
6 Insurance Code, is amended by adding Subtitle I to read as follows:

7 SUBTITLE I. SPECIALIZED COVERAGES

8 CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

9 CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

10 SUBTITLE I. SPECIALIZED COVERAGES

11 CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

12 SUBCHAPTER A. GENERAL PROVISIONS

13 Sec. 1651.001. APPLICABILITY OF CHAPTER

14 Sec. 1651.002. EXEMPTIONS

15 Sec. 1651.003. LONG-TERM CARE BENEFIT PLAN DEFINED

16 Sec. 1651.004. RULES

17 Sec. 1651.005. CONSTRUCTION OF CHAPTER

18 Sec. 1651.006. CONFLICTS WITH OTHER PROVISIONS

19 [Sections 1651.007-1651.050 reserved for expansion]

20 SUBCHAPTER B. BENEFIT PLAN STANDARDS

21 Sec. 1651.051. MINIMUM STANDARDS

22 Sec. 1651.052. PREEXISTING CONDITIONS

23 Sec. 1651.053. LOSS RATIO STANDARDS

24 Sec. 1651.054. NOTICE OF RIGHT TO REFUND

25 Sec. 1651.055. RATE STABILIZATION

26 CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

27 SUBCHAPTER A. GENERAL PROVISIONS

1 Sec. 1651.001. APPLICABILITY OF CHAPTER. (a)
2 Notwithstanding Section 101.053(b)(5) and subject to Subsection
3 (b), this chapter applies only to:

4 (1) an individual long-term care benefit plan that is
5 delivered or issued for delivery in this state;

6 (2) a group long-term care benefit plan that is:
7 (A) delivered or issued for delivery in this
8 state; and

9 (B) issued to an eligible group as described by
10 Subchapter B, Chapter 1251;

11 (3) a certificate issued under a group long-term care
12 benefit plan issued to an eligible group as described by Subchapter
13 B, Chapter 1251, if the certificate is delivered or issued for
14 delivery in this state, regardless of the place where the plan is
15 delivered or issued for delivery; and

16 (4) an evidence of coverage delivered or issued for
17 delivery in this state for long-term care.

18 (b) This chapter applies only to a policy, certificate, or
19 evidence of coverage that is issued by:

20 (1) a capital stock insurance company, including a
21 life, health and accident, or general casualty insurance company;

22 (2) a mutual life insurance company;

23 (3) a mutual assessment life insurance company,
24 including a statewide mutual assessment corporation, local mutual
25 aid association, and burial association;

26 (4) a mutual or mutual assessment association,
27 including an association subject to Section 887.101;

1 (5) a mutual insurance company other than a life
2 insurance company;

3 (6) a mutual or natural premium life or casualty
4 insurance company;

5 (7) a fraternal benefit society;

6 (8) a Lloyd's plan insurer;

7 (9) a reciprocal or interinsurance exchange;

8 (10) a nonprofit medical, hospital, or dental service
9 corporation, including a company subject to Chapter 842;

10 (11) a stipulated premium company;

11 (12) a health maintenance organization under Chapter
12 843; or

13 (13) another insurer required to be licensed by the
14 department. (V.T.I.C. Art. 3.70-12, Secs. 1(a), (b), 2(2), (3).)

15 Sec. 1651.002. EXEMPTIONS. This chapter does not apply to:

16 (1) a certificate that is delivered or issued for
17 delivery in this state under a single employer or labor union group
18 policy that is delivered or issued for delivery outside this state;
19 or

20 (2) a benefit plan that is not advertised, marketed,
21 or offered as a long-term care benefit plan or nursing home benefit
22 plan. (V.T.I.C. Art. 3.70-12, Secs. 1(d), (e).)

23 Sec. 1651.003. LONG-TERM CARE BENEFIT PLAN DEFINED. (a) In
24 this chapter, "long-term care benefit plan" means an insurance
25 policy or group certificate, or rider to the policy or certificate,
26 or evidence of coverage issued by a health maintenance organization
27 subject to Chapter 843, that is advertised or marketed as

1 providing, or offered or designed to provide, coverage for not less
2 than 12 consecutive months for each covered individual on an
3 expense-incurred, indemnity, prepaid, or other basis for one or
4 more necessary or medically necessary diagnostic, preventive,
5 therapeutic, rehabilitative, maintenance, or personal care
6 services provided in a setting other than an acute care unit of a
7 hospital.

8 (b) The term includes a plan or rider, other than a group or
9 individual annuity or life insurance policy, that provides for
10 payment of benefits based on cognitive impairment or the loss of
11 functional capacity.

12 (c) The term does not include an insurance policy, group
13 certificate, or evidence of coverage that is offered primarily to
14 provide:

15 (1) basic Medicare supplement coverage, basic
16 hospital expense coverage, basic medical-surgical expense
17 coverage, hospital confinement indemnity coverage, major medical
18 expense coverage, disability income protection coverage,
19 accident-only coverage, specified disease or specified accident
20 coverage, or limited benefit health coverage; or

21 (2) basic or single health care services. (V.T.I.C.
22 Art. 3.70-12, Sec. 2(4).)

23 Sec. 1651.004. RULES. (a) In addition to other rules
24 required or authorized by this chapter, the department may adopt
25 reasonable rules that are necessary and proper to carry out this
26 chapter.

27 (b) Rules adopted under this section must include

1 requirements no less favorable than the minimum standards for
2 long-term care benefit plans adopted in any model laws or
3 regulations relating to minimum standards for benefits for
4 long-term care benefit plans and in accordance with all applicable
5 federal law. (V.T.I.C. Art. 3.70-12, Sec. 7.)

6 Sec. 1651.005. CONSTRUCTION OF CHAPTER. This chapter may
7 not be construed to enlarge the powers of an entity listed in
8 Section 1651.001. (V.T.I.C. Art. 3.70-12, Sec. 1(c).)

9 Sec. 1651.006. CONFLICTS WITH OTHER PROVISIONS. This
10 chapter prevails to the extent of any conflict with another
11 provision of this code. (V.T.I.C. Art. 3.70-12, Sec. 6 (part).)

12 [Sections 1651.007-1651.050 reserved for expansion]

13 SUBCHAPTER B. BENEFIT PLAN STANDARDS

14 Sec. 1651.051. MINIMUM STANDARDS. (a) The commissioner by
15 rule shall establish:

16 (1) specific standards for provisions of long-term
17 care benefit plans; and

18 (2) standards for full and fair disclosure setting
19 forth the manner, content, and required disclosures for the
20 marketing and sale of those benefit plans.

21 (b) The standards are in addition to and must be in
22 accordance with:

23 (1) applicable laws of this state, including Chapter
24 1201;

25 (2) applicable federal law; and

26 (3) any rules, regulations, and standards required by
27 federal law.

- 1 (c) The standards must address:
- 2 (1) terms of renewability;
- 3 (2) initial and subsequent conditions of eligibility;
- 4 (3) nonduplication of coverage;
- 5 (4) coverage of dependents;
- 6 (5) coverage of parents of the insured or enrollee and
- 7 parents of the spouse of the insured or enrollee;
- 8 (6) preexisting conditions;
- 9 (7) termination of insurance;
- 10 (8) continuation or conversion;
- 11 (9) probationary periods;
- 12 (10) benefit limitations, exceptions, and reductions;
- 13 (11) elimination periods;
- 14 (12) requirements for replacement;
- 15 (13) recurrent conditions;
- 16 (14) definitions of terms; and
- 17 (15) inflation protection.
- 18 (d) The standards may:
- 19 (1) establish standard claim forms;
- 20 (2) establish standard benefits for:
- 21 (A) skilled nursing care;
- 22 (B) intermediate nursing care;
- 23 (C) custodial care; and
- 24 (D) home health care;
- 25 (3) require coverage for skilled nursing care,
- 26 intermediate nursing care, and custodial care to facilitate
- 27 comparison among long-term care products;

1 (4) require long-term care benefit plan issuers to
2 offer coverage for home health care benefits;

3 (5) require that rates may not be increased for a
4 covered individual unless:

5 (A) the covered individual requests and receives
6 a change of benefits; or

7 (B) the increase applies to all members of the
8 class to which the individual has been assigned by the benefit plan
9 issuer; or

10 (6) require a benefit plan issuer to pay for a service
11 covered by the benefit plan that is provided by an institution
12 licensed to provide that service under Chapter 242, Health and
13 Safety Code.

14 (e) Rules adopted under this section must include
15 requirements no less favorable than the minimum standards of
16 benefits for long-term care benefit plans adopted in any model laws
17 or regulations relating to minimum standards for benefits for
18 long-term care benefit plans and required by federal law.
19 (V.T.I.C. Art. 3.70-12, Secs. 3(a), (b), (c), (d).)

20 Sec. 1651.052. PREEXISTING CONDITIONS. (a) A long-term
21 care benefit plan may not contain a provision that denies coverage
22 for a claim for losses incurred more than six months after the
23 effective date of coverage for a preexisting condition.

24 (b) A long-term care benefit plan may not define a
25 preexisting condition more restrictively than as a condition for
26 which medical advice was given or treatment was recommended by or
27 received from a physician within six months before the effective

1 date of coverage.

2 (c) The commissioner by rule may:

3 (1) establish additional reasonable regulation of
4 preexisting conditions consistent with this section and Section
5 1651.051; and

6 (2) extend a limitation period specified in this
7 section as to a specific age group category in a specific benefit
8 plan form if the commissioner finds that the extension is in the
9 best interest of the public.

10 (d) Rules adopted under this section must comply with
11 Section 1651.051(e). (V.T.I.C. Art. 3.70-12, Secs. 3(d), (e).)

12 Sec. 1651.053. LOSS RATIO STANDARDS. (a) A long-term care
13 benefit plan must provide a benefit plan holder with benefits that
14 are reasonable in relation to the rates charged.

15 (b) The commissioner shall adopt reasonable rules to
16 establish minimum standards for loss ratios of long-term care
17 benefit plans on the basis of:

- 18 (1) incurred claims experience;
19 (2) earned premiums;
20 (3) the period for which rates are computed to provide
21 coverage;
22 (4) experienced and projected trends;
23 (5) concentration of experience within early benefit
24 plan duration;
25 (6) expected claim fluctuations;
26 (7) experience refunds;
27 (8) adjustments;

1 (9) dividends;
2 (10) renewability features;
3 (11) all relevant expense factors;
4 (12) interest;
5 (13) reserves;
6 (14) mix of business by risk classification; and
7 (15) product features otherwise affecting claims
8 experience.

9 (c) Annually, each entity providing a long-term care
10 benefit plan in this state shall:

11 (1) file its rates, rating schedule, and supporting
12 documentation to demonstrate compliance with the applicable loss
13 ratio standards of this state; and

14 (2) comply with any other filing requirement adopted
15 by the commissioner relating to loss ratios.

16 (d) Rules adopted under this section shall be no less
17 favorable to the holders of long-term care benefit plans than any
18 model laws, rules, and regulations adopted in connection with
19 minimum standards for benefits for long-term care benefit plans.

20 (V.T.I.C. Art. 3.70-12, Sec. 4.)

21 Sec. 1651.054. NOTICE OF RIGHT TO REFUND. (a) In this
22 section, "applicant" means:

23 (1) in the case of an individual long-term care
24 benefit plan, the individual who seeks to contract for insurance or
25 other health benefits; and

26 (2) in the case of a group long-term care benefit plan,
27 the proposed certificate holder.

1 (b) A long-term care benefit plan must have a notice
2 prominently printed on the first page of or attached to the benefit
3 plan document.

4 (c) The notice must state in substance that, if the
5 applicant is not satisfied for any reason after examining the
6 benefit plan document, the applicant is entitled to:

7 (1) return the document not later than the 30th day
8 after the date of its delivery; and

9 (2) have any premium refunded.

10 (d) The long-term care benefit plan issuer shall pay in a
11 timely manner the refund directly to the individual or entity that
12 paid the premium. (V.T.I.C. Art. 3.70-12, Secs. 2(1), 5.)

13 Sec. 1651.055. RATE STABILIZATION. (a) The commissioner
14 shall adopt rules to stabilize long-term care premium rates by:

15 (1) ensuring that:

16 (A) initial rates for long-term care benefit plan
17 forms are adequate; and

18 (B) any rate schedule increases for long-term
19 care benefit plans made after issuance of the plans are justified,
20 adequate, and reasonable in relation to benefits provided to plan
21 holders;

22 (2) requiring any appropriate plan terms;

23 (3) imposing penalties on insurers or other entities
24 subject to this chapter that violate a rule adopted under this
25 section; and

26 (4) protecting plan holders affected by a rate
27 schedule increase.

(b) Except as provided by this subsection, the commissioner shall adopt rules under this section that are consistent with nationally recognized models relating to the stabilization of long-term care premium rates that existed on January 1, 2001. The commissioner may adopt rules consistent with any of those models as they are amended after January 1, 2001. The commissioner shall adopt rules under this subsection that:

(1) to the extent possible, contribute to the uniformity of state laws; and

(2) protect consumers.

(c) In adopting rules under this section, the commissioner may exempt long-term care benefit plans from the requirements of Sections 1651.053(a), (b), and (d). (V.T.I.C. Art. 3.70-12, Sec. 5A.)

CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1652.001. DEFINITIONS

Sec. 1652.002. MEDICARE SUPPLEMENT BENEFIT PLAN

Sec. 1652.003. APPLICABILITY OF CHAPTER

Sec. 1652.004. CONSTRUCTION OF CHAPTER

Sec. 1652.005. RULES NECESSARY FOR CERTIFICATION

[Sections 1652.006-1652.050 reserved for expansion]

SUBCHAPTER B. BENEFITS

Sec. 1652.051. MINIMUM STANDARDS

Sec. 1652.052. MINIMUM STANDARDS FOR BENEFITS AND CLAIM

PAYMENTS

Sec. 1652.053. DUPLICATE BENEFITS PROHIBITED

1 Sec. 1652.054. BASIC PLAN

2 Sec. 1652.055. ADDITIONAL BENEFITS

3 Sec. 1652.056. COVERAGE FOR MAMMOGRAPHY

4 Sec. 1652.057. WAIVER OF WAITING PERIOD

5 Sec. 1652.058. COVERAGE FOR PREEXISTING CONDITION

6 [Sections 1652.059-1652.100 reserved for expansion]

7 SUBCHAPTER C. LOSS RATIO STANDARDS

8 Sec. 1652.101. LOSS RATIO STANDARDS

9 Sec. 1652.102. FILING REQUIREMENTS

10 Sec. 1652.103. REVIEW OF PREMIUM INCREASES

11 Sec. 1652.104. BENEFIT CHANGES

12 Sec. 1652.105. REPORTING LOSS RATIO INFORMATION TO SECRETARY

13 OF HEALTH AND HUMAN SERVICES

14 [Sections 1652.106-1652.150 reserved for expansion]

15 SUBCHAPTER D. CONSUMER INFORMATION AND NOTICE

16 Sec. 1652.151. RULES RELATING TO DISCLOSURE

17 Sec. 1652.152. OUTLINE OF COVERAGE

18 Sec. 1652.153. INFORMATIONAL BROCHURE

19 Sec. 1652.154. NOTICE RELATING TO OTHER TYPES OF COVERAGE

20 Sec. 1652.155. RIGHT TO RETURN FOR REFUND; NOTICE

21 Sec. 1652.156. ADVERTISING FILING REQUIREMENTS

22 [Sections 1652.157-1652.200 reserved for expansion]

23 SUBCHAPTER E. AGENTS

24 Sec. 1652.201. INFORMATION PROVIDED TO AGENTS

25 Sec. 1652.202. PERMITTED COMPENSATION ARRANGEMENTS

26 CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

27 SUBCHAPTER A. GENERAL PROVISIONS

1 Sec. 1652.001. DEFINITIONS. In this chapter:

2 (1) "Applicant" means:

3 (A) an individual who seeks to contract for
4 insurance or other health benefits under an individual Medicare
5 supplement benefit plan; or

6 (B) the proposed certificate holder of a group
7 Medicare supplement benefit plan.

8 (2) "Approved regulatory program" means a state
9 regulatory program that complies with the requirements of Section
10 1882, Social Security Act (42 U.S.C. Section 1395ss).

11 (3) "Medicare" means the Health Insurance for the Aged
12 Act (42 U.S.C. Section 1395 et seq.), as amended. (V.T.I.C. Art.
13 3.74, Secs. 1(b)(1), (4); New.)

14 Sec. 1652.002. MEDICARE SUPPLEMENT BENEFIT PLAN. (a)
15 "Medicare supplement benefit plan" means a group or individual
16 policy of accident and health insurance, a subscriber contract of a
17 group hospital service corporation operating under Chapter 842, or,
18 to the extent required by federal law, an evidence of coverage
19 issued by a health maintenance organization operating under Chapter
20 843 that is advertised, marketed, or designed primarily as a
21 supplement to reimbursements under Medicare for the hospital,
22 medical, or surgical expenses of an individual eligible for
23 Medicare.

24 (b) A policy, contract, subscriber contract, or evidence of
25 coverage is not considered to be a Medicare supplement benefit plan
26 if it is:

27 (1) a policy, contract, subscriber contract, or

1 evidence of coverage of one or more employers or labor
2 organizations, or of the trustees of a fund established by one or
3 more employers or labor organizations, or a combination, for
4 employees or former employees, or a combination, or for members or
5 former members, or a combination, of the labor organizations;

6 (2) a policy or health care benefit plan, including a
7 policy or contract of group insurance, a group contract of a group
8 hospital service corporation operating under Chapter 842, or a
9 group evidence of coverage issued by a health maintenance
10 organization operating under Chapter 843 that is not marketed or
11 held to be a Medicare supplement benefit plan; or

12 (3) an individual or group evidence of coverage issued
13 in accordance with a contract under Section 1833 or 1876, Social
14 Security Act (42 U.S.C. Section 1395l or 1395mm), by a health
15 maintenance organization operating under Chapter 843.

16 (c) The commissioner by rule may modify the definition of
17 "Medicare supplement benefit plan" provided by Subsection (a) to
18 the extent necessary for this state to qualify as a state with an
19 approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 1(b)(3).)

20 Sec. 1652.003. APPLICABILITY OF CHAPTER. This chapter
21 applies to an individual or group Medicare supplement benefit plan
22 delivered or issued for delivery in this state and, regardless of
23 the place where the plan was delivered or issued for delivery, a
24 certificate that was issued under a group Medicare supplement
25 benefit plan and delivered or issued for delivery in this state, if
26 the plan or certificate is issued by:

27 (1) a capital stock insurance company, including a

1 life, health and accident, and general casualty insurance company;

2 (2) a mutual life insurance company;

3 (3) a mutual assessment life insurance company,
4 including a statewide mutual assessment company, local mutual aid
5 association, and burial association;

6 (4) a mutual or mutual assessment association of any
7 kind, including an association subject to Section 887.102;

8 (5) a mutual insurance company other than a life
9 insurance company;

10 (6) a mutual or natural premium life or casualty
11 insurance company;

12 (7) a fraternal benefit society;

13 (8) a Lloyd's plan;

14 (9) a reciprocal or interinsurance exchange;

15 (10) a nonprofit hospital, medical, or dental service
16 corporation, including a corporation operating under Chapter 842;

17 (11) a stipulated premium company;

18 (12) another insurer that by law is required to be
19 authorized by the department; or

20 (13) a health maintenance organization operating
21 under Chapter 843, to the extent required by federal law. (V.T.I.C.
22 Art. 3.74, Secs. 1(a) (part), (b)(2).)

23 Sec. 1652.004. CONSTRUCTION OF CHAPTER. (a) This chapter
24 may not be construed to enlarge the powers of an entity described by
25 Section 1652.003.

26 (b) This chapter controls to the extent of any conflict with
27 another provision of this code. (V.T.I.C. Art. 3.74, Secs. 1(a)

1 (part), 7 (part).)

2 Sec. 1652.005. RULES NECESSARY FOR CERTIFICATION. In
3 addition to other rules required or authorized by this chapter, the
4 commissioner shall adopt reasonable rules necessary and proper to
5 carry out this chapter, including rules adopted in accordance with
6 federal law relating to the regulation of Medicare supplement
7 benefit plan coverage that are necessary for this state to obtain or
8 retain certification as a state with an approved regulatory
9 program. (V.T.I.C. Art. 3.74, Sec. 10.)

10 [Sections 1652.006-1652.050 reserved for expansion]

11 SUBCHAPTER B. BENEFITS

12 Sec. 1652.051. MINIMUM STANDARDS. (a) The commissioner
13 shall adopt reasonable rules to establish specific standards for
14 provisions in Medicare supplement benefit plans and standards for
15 facilitating comparisons of different Medicare supplement benefit
16 plans. The standards are in addition to and must be in accordance
17 with:

18 (1) applicable laws of this state, including Chapters
19 842 and 1201;

20 (2) applicable federal law, rules, regulations, and
21 standards; and

22 (3) any model rules and regulations required by
23 federal law, including Section 1882, Social Security Act (42 U.S.C.
24 Section 1395ss).

25 (b) The standards may include provisions relating to:

26 (1) terms of renewability;

27 (2) initial and subsequent conditions of eligibility;

- (3) nonduplication of coverage;
- (4) probationary periods;
- (5) benefit limitations, exceptions, and reductions;
- (6) elimination periods;
- (7) requirements for replacement;
- (8) recurrent conditions;
- (9) definitions of terms; and
- (10) exclusions required by state or federal law.

(c) The commissioner may adopt reasonable rules that specifically prohibit benefit plan provisions that:

(1) are not otherwise specifically authorized by statute; and

(2) the commissioner determines are unjust, unfair, or unfairly discriminatory to a person who is covered or proposed for coverage.

(d) Rules adopted under this section must include requirements that are at least equal to those required by federal law, rules, regulations, and standards, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 2(c), (d), (f).)

Sec. 1652.052. MINIMUM STANDARDS FOR BENEFITS AND CLAIM PAYMENTS. (a) The commissioner shall adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

(b) The standards for benefits and claim payments must include the requirements for certification of Medicare supplement benefit plans prescribed by Section 1882, Social Security Act (42

1 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 3.)

2 Sec. 1652.053. DUPLICATE BENEFITS PROHIBITED. A Medicare
3 supplement benefit plan or certificate in force in this state may
4 not contain benefits that duplicate benefits provided by Medicare.
5 (V.T.I.C. Art. 3.74, Sec. 2(a).)

6 Sec. 1652.054. BASIC PLAN. An entity described by Section
7 1652.003 that offers for sale in this state a Medicare supplement
8 benefit plan must offer a basic Medicare supplement benefit plan
9 that:

10 (1) provides only those benefits common to all
11 Medicare supplement benefit plans; and

12 (2) meets but does not exceed the minimum standards of
13 benefits for Medicare supplement benefit plans adopted by the
14 commissioner and authorized by Section 1882, Social Security Act
15 (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 2(b)
16 (part).)

17 Sec. 1652.055. ADDITIONAL BENEFITS. (a) In addition to the
18 basic Medicare supplement benefit plan described by Section
19 1652.054, an entity may offer additional Medicare supplement
20 benefit plans for sale in this state.

21 (b) The combination of benefits provided by an additional
22 plan must conform to one of the benefit packages adopted by the
23 commissioner and authorized by Section 1882, Social Security Act
24 (42 U.S.C. Section 1395ss).

25 (c) The commissioner by rule shall provide for the approval
26 of new or innovative benefits that may be provided in a plan other
27 than the basic plan and that otherwise comply with this subchapter.

1 The benefits must:

2 (1) be offered in a manner consistent with the goal of
3 Medicare supplement benefit plan simplification; and

4 (2) meet the requirements prescribed by Section 1882,
5 Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art.
6 3.74, Sec. 2(b) (part).)

7 Sec. 1652.056. COVERAGE FOR MAMMOGRAPHY. (a) In this
8 section, "low-dose mammography" means the x-ray examination of the
9 breast using equipment dedicated specifically for mammography,
10 including the x-ray tube, filter, compression device, screens,
11 films, and cassettes, with an average radiation exposure delivery
12 of less than one rad mid-breast, with two views for each breast.

13 (b) Each Medicare supplement benefit plan must include
14 coverage for an annual screening by low-dose mammography for the
15 presence of occult breast cancer.

16 (c) The coverage for the annual screening may not be less
17 favorable than coverage for other radiological examinations and
18 must be subject to the same dollar limits, deductibles, and
19 coinsurance factors. (V.T.I.C. Art. 3.74, Sec. 3A.)

20 Sec. 1652.057. WAIVER OF WAITING PERIOD. (a) An entity
21 that delivers or issues for delivery in this state a Medicare
22 supplement benefit plan or certificate that replaces a Medicare
23 supplement benefit plan or certificate shall give credit for the
24 satisfaction or partial satisfaction of any waiting period,
25 elimination period, or probationary period for a preexisting
26 condition that has been satisfied under the plan being replaced.

27 (b) A replacement plan that clearly provides a new or

1 additional benefit may include appropriate and clearly stated
2 periods as a condition for payment of the new or additional benefit.
3 (V.T.I.C. Art. 3.74, Sec. 8.)

4 Sec. 1652.058. COVERAGE FOR PREEXISTING CONDITION. (a) A
5 Medicare supplement benefit plan may not contain a provision that
6 excludes coverage for a claim for losses incurred more than six
7 months after the effective date of coverage for a preexisting
8 condition.

9 (b) A Medicare supplement benefit plan may not define a
10 preexisting condition more restrictively than a condition for which
11 medical advice was given or treatment was recommended by or
12 received from a physician within six months before the effective
13 date of coverage. (V.T.I.C. Art. 3.74, Sec. 2(e).)

14 [Sections 1652.059-1652.100 reserved for expansion]

15 SUBCHAPTER C. LOSS RATIO STANDARDS

16 Sec. 1652.101. LOSS RATIO STANDARDS. (a) A Medicare
17 supplement benefit plan must return to a plan holder benefits that
18 are reasonable in relation to the premium charged.

19 (b) The commissioner shall adopt reasonable rules to
20 establish minimum loss ratio standards for Medicare supplement
21 benefit plans. The standards must be established:

22 (1) on the basis of incurred claims experience and
23 earned premiums for the entire period for which rates are computed
24 to provide coverage;

25 (2) in accordance with accepted actuarial principles
26 and practices; and

27 (3) to the extent necessary for the state to obtain or

1 retain certification as a state with an approved regulatory
2 program. (V.T.I.C. Art. 3.74, Secs. 4(a), (d).)

3 Sec. 1652.102. FILING REQUIREMENTS. (a) Annually, each
4 entity providing Medicare supplement benefit plans in this state
5 shall file with the department the entity's rates, rating schedule,
6 and supporting documentation demonstrating that:

7 (1) the entity is complying with the applicable loss
8 ratio standards of this state; and

9 (2) the actual and expected losses in relation to
10 premiums comply with the requirements of this subchapter and the
11 rules adopted by the commissioner.

12 (b) The documentation required by Subsection (a) must
13 include a report of the ratio of incurred losses to covered premiums
14 for the preceding calendar year, illustrated by calendar year of
15 issue.

16 (c) The commissioner may adopt rules relating to filing
17 requirements for rates, rating schedules, and loss ratios.
18 (V.T.I.C. Art. 3.74, Secs. 4(b), (c).)

19 Sec. 1652.103. REVIEW OF PREMIUM INCREASES. (a) The
20 commissioner by rule shall provide a process for reviewing and
21 approving or disapproving a proposed premium increase relating to a
22 Medicare supplement benefit plan.

23 (b) The rules must comply with federal law, including
24 Section 1882, Social Security Act (42 U.S.C. Section 1395ss).
25 (V.T.I.C. Art. 3.74, Sec. 4(f).)

26 Sec. 1652.104. BENEFIT CHANGES. (a) Before the date on
27 which a Medicare benefit change required by federal law takes

1 effect, each entity providing in this state a Medicare supplement
2 benefit plan existing on the effective date of the change shall file
3 with the commissioner, in accordance with Chapter 1701:

4 (1) each appropriate premium adjustment necessary to
5 produce the loss ratios originally anticipated for the applicable
6 plan, accompanied by any supporting documents necessary to justify
7 the adjustment; and

8 (2) each appropriate rider, endorsement, or plan form
9 necessary to modify the coverage so as to eliminate benefit
10 duplications with Medicare.

11 (b) A rider, endorsement, or plan form required by
12 Subsection (a) must provide a clear description of the Medicare
13 supplement benefits provided by the plan. (V.T.I.C. Art. 3.74,
14 Sec. 4(e).)

15 Sec. 1652.105. REPORTING LOSS RATIO INFORMATION TO
16 SECRETARY OF HEALTH AND HUMAN SERVICES. To the extent necessary for
17 this state to obtain or retain certification as a state with an
18 approved regulatory program, the department shall comply with
19 federal requirements relating to periodic reporting of loss ratio
20 information to the secretary of health and human services, based on
21 a uniform methodology, as authorized by federal law. (V.T.I.C.
22 Art. 3.74, Sec. 4(g).)

23 [Sections 1652.106-1652.150 reserved for expansion]

24 SUBCHAPTER D. CONSUMER INFORMATION AND NOTICE

25 Sec. 1652.151. RULES RELATING TO DISCLOSURE. The rules
26 adopted under Sections 1652.152, 1652.153, and 1652.154 must
27 include provisions and requirements that are at least equal to

1 those required by federal law, including the rules, regulations,
2 and standards adopted under Section 1882, Social Security Act (42
3 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 5(b) (part),
4 (f).)

5 Sec. 1652.152. OUTLINE OF COVERAGE. (a) To provide for
6 full and fair disclosure in the sale of Medicare supplement benefit
7 plans, a Medicare supplement benefit plan or certificate may not be
8 delivered or issued for delivery in this state unless an outline of
9 coverage that complies with this section is delivered to the
10 applicant when the applicant applies for the coverage.

11 (b) The commissioner by rule shall prescribe the format and
12 content of the outline of coverage required by Subsection (a). The
13 rules must address the style, arrangement, and overall appearance
14 of the outline of coverage, including the size, color, and
15 prominence of type and the arrangement of text and captions.
16 (V.T.I.C. Art. 3.74, Secs. 5(a), (b) (part).)

17 Sec. 1652.153. INFORMATIONAL BROCHURE. (a) The
18 commissioner by rule may prescribe a standard form and the contents
19 of an informational brochure intended to improve the ability of an
20 individual eligible for Medicare to understand Medicare and to
21 select the most appropriate Medicare supplement coverage.

22 (b) Except as provided by Subsection (c), the commissioner
23 by rule may require that the informational brochure be provided to
24 an individual eligible for Medicare concurrently with delivery of
25 the outline of coverage.

26 (c) If the plan is a direct response Medicare supplement
27 benefit plan, the commissioner by rule may require that the

1 informational brochure be provided on request to an individual
2 eligible for Medicare at any time not later than the time the plan
3 is delivered. (V.T.I.C. Art. 3.74, Sec. 5(c).)

4 Sec. 1652.154. NOTICE RELATING TO OTHER TYPES OF COVERAGE.

5 (a) The commissioner may adopt reasonable rules for captions or
6 notice requirements for each accident and health insurance policy,
7 subscriber contract, or evidence of coverage sold to an individual
8 eligible for Medicare that are determined to be in the public
9 interest and designed to inform the individual that a particular
10 coverage is not a Medicare supplement benefit plan. This
11 subsection does not apply to:

- 12 (1) a Medicare supplement benefit plan;
13 (2) a disability income policy;
14 (3) a basic, catastrophic, or major medical expense
15 policy;
16 (4) a single premium nonrenewable policy; or
17 (5) another policy, contract, or subscriber contract
18 described by Section 1652.002(b)(1) or (2).

19 (b) The commissioner may adopt reasonable rules to govern
20 the full and fair disclosure of information relating to replacing
21 an accident and health insurance policy, a subscriber contract, or
22 a certificate by an individual eligible for Medicare. (V.T.I.C.
23 Art. 3.74, Secs. 5(d), (e).)

24 Sec. 1652.155. RIGHT TO RETURN FOR REFUND; NOTICE. (a) If
25 an applicant is not satisfied for any reason after examining a
26 Medicare supplement benefit plan document or certificate, the
27 applicant is entitled to receive a refund of the premium if the

1 applicant returns the document or certificate not later than the
2 30th day after the date it is delivered.

3 (b) The entity issuing the plan or certificate shall refund
4 the premium directly to the applicant in a timely manner.

5 (c) A Medicare supplement benefit plan or certificate must
6 have a notice stating the substance prescribed by Subsection (a)
7 prominently printed on the first page of or attached to the plan or
8 certificate. (V.T.I.C. Art. 3.74, Sec. 6.)

9 Sec. 1652.156. ADVERTISING FILING REQUIREMENTS. (a) The
10 commissioner shall adopt reasonable rules to require each entity
11 described by Section 1652.003 to file with the department a copy of
12 any advertisement relating to Medicare supplement benefit plans
13 that the entity intends to use in this state. The rules must
14 require that the entity file the copy not later than the 60th day
15 before the date of intended use.

16 (b) At the expiration of the 60-day period provided by
17 Subsection (a), an advertisement filed in accordance with that
18 subsection is considered acceptable, unless before the end of that
19 60-day period the department notifies the entity of the
20 advertisement's nonacceptance.

21 (c) An entity may not use an advertisement for Medicare
22 supplement benefit plans that does not comply with state law,
23 including department rules. (V.T.I.C. Art. 3.74, Sec. 9.)

24 [Sections 1652.157-1652.200 reserved for expansion]

25 SUBCHAPTER E. AGENTS

26 Sec. 1652.201. INFORMATION PROVIDED TO AGENTS. (a) An
27 entity that offers a Medicare supplement benefit plan for sale in

1 this state shall provide to each agent authorized to sell that plan
2 information relating to:

3 (1) Medicare;

4 (2) the Medicare supplement benefit plans offered by
5 that entity; and

6 (3) the agent's ethical obligations to clients.

7 (b) The commissioner by rule may prescribe the information
8 that must be provided under this section. (V.T.I.C. Art. 3.74, Sec.
9 9A.)

10 Sec. 1652.202. PERMITTED COMPENSATION ARRANGEMENTS. (a)
11 The commissioner by rule shall limit the commission or other
12 compensation that may be paid to an agent for the sale of a Medicare
13 supplement benefit plan or certificate, including a replacement
14 plan or certificate.

15 (b) The rules must conform to, but may not be more
16 restrictive than, the requirements of federal law necessary for
17 this state to obtain or retain certification as a state with an
18 approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 9B.)

19 SECTION 5. TITLE 9, INSURANCE CODE. The Insurance Code is
20 amended by adding Title 9 to read as follows:

21 TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

22 CHAPTER 1701. POLICY FORMS

23 TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

24 CHAPTER 1701. POLICY FORMS

25 SUBCHAPTER A. GENERAL PROVISIONS

26 Sec. 1701.001. DEFINITION

27 Sec. 1701.002. APPLICABILITY OF CHAPTER TO FORMS OF

CERTAIN DOCUMENTS

Sec. 1701.003. APPLICABILITY OF CHAPTER TO CERTAIN
INSURERS

Sec. 1701.004. CONSTRUCTION OF CHAPTER

Sec. 1701.005. EXEMPTIONS

[Sections 1701.006-1701.050 reserved for expansion]

SUBCHAPTER B. FILING REQUIREMENT

Sec. 1701.051. FILING REQUIRED

Sec. 1701.052. FILE AND USE

Sec. 1701.053. FILING FEE

Sec. 1701.054. APPROVAL OF FORM

Sec. 1701.055. DISAPPROVAL OF FORM OR WITHDRAWAL

OF APPROVAL OR EXEMPTION

Sec. 1701.056. USE OF DISAPPROVED FORM PROHIBITED

Sec. 1701.057. WITHDRAWAL OF INDIVIDUAL ACCIDENT AND

HEALTH INSURANCE POLICY FORM APPROVAL

Sec. 1701.058. RECONSIDERATION OF FORM

Sec. 1701.059. REPLACEMENT OR AMENDMENT OF DOCUMENT

Sec. 1701.060. GENERAL RULEMAKING AUTHORITY

[Sections 1701.061-1701.100 reserved for expansion]

SUBCHAPTER C. SANCTIONS; APPLICABILITY OF OTHER LAWS

Sec. 1701.101. RESTITUTION

Sec. 1701.102. LIMIT ON SANCTIONS

Sec. 1701.103. APPLICABILITY OF OTHER LAWS

[Sections 1701.104-1701.150 reserved for expansion]

SUBCHAPTER D. CERTAIN POLICY APPLICATION FORMS

Sec. 1701.151. POLICY APPLICATION FORM FOR INDIVIDUAL

ACCIDENT AND HEALTH POLICY

CHAPTER 1701. POLICY FORMS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1701.001. DEFINITION. In this chapter, "use" includes issue and deliver. (New.)

Sec. 1701.002. APPLICABILITY OF CHAPTER TO FORMS OF CERTAIN DOCUMENTS. This chapter applies to the form of the following document:

(1) a policy, contract, or certificate of:

(A) accident or health insurance, including group accident or health insurance;

(B) medical or surgical insurance, including group medical or surgical insurance;

(C) life or term insurance, including group life or term insurance;

(D) endowment insurance;

(E) industrial life insurance; or

(F) fraternal benefit insurance;

(2) an annuity or pure endowment contract, including a group annuity contract;

(3) an application attached or required to be attached to the policy, contract, or certificate; or

(4) a rider or endorsement to be attached to, printed on, or used in connection with the policy, contract, or certificate. (V.T.I.C. Art. 3.42, Secs. (a) (part), (b) (part).)

Sec. 1701.003. APPLICABILITY OF CHAPTER TO CERTAIN INSURERS. (a) Except as provided by Subsection (b), this chapter

1 applies to any insurer that uses a document described by Section
2 1701.002 in this state, including:

3 (1) a life, accident, health, or casualty insurance
4 company;

5 (2) a mutual life insurance company;

6 (3) a mutual insurance company other than a mutual
7 life insurance company;

8 (4) a mutual or natural premium life insurance
9 company;

10 (5) a general casualty company;

11 (6) a Lloyd's plan;

12 (7) a reciprocal or interinsurance exchange;

13 (8) a fraternal benefit society; and

14 (9) a group hospital service corporation.

15 (b) This chapter does not apply to a society, company, or
16 other insurer whose activities are by statute exempt from
17 department control and that is entitled by statute to a certificate
18 from the department showing that exempt status. (V.T.I.C. Art.
19 3.42, Sec. (a) (part).)

20 Sec. 1701.004. CONSTRUCTION OF CHAPTER. This chapter may
21 not be construed to enlarge the powers of an insurer subject to this
22 chapter. (V.T.I.C. Art. 3.42, Sec. (a) (part).)

23 Sec. 1701.005. EXEMPTIONS. (a) This chapter does not apply
24 to a rider or endorsement that:

25 (1) is used at the request of the holder of a policy,
26 contract, or certificate subject to this chapter; and

27 (2) relates to:

1 (A) the manner of distribution of benefits under
2 the policy, contract, or certificate; or

3 (B) the reservation of rights and benefits under
4 the policy, contract, or certificate.

5 (b) The commissioner by written order may exempt a document
6 from the requirements of this chapter for the period the
7 commissioner considers proper if the commissioner determines that:

8 (1) this chapter may not practically be applied to the
9 document;

10 (2) the document's preparation, use, and meaning have
11 become routine or commonplace; or

12 (3) the filing and approval of the form of the document
13 are not desirable, appropriate, required, or necessary for the
14 protection of the public. (V.T.I.C. Art. 3.42, Secs. (b) (part),
15 (h) (part).)

16 [Sections 1701.006-1701.050 reserved for expansion]

17 SUBCHAPTER B. FILING REQUIREMENT

18 Sec. 1701.051. FILING REQUIRED. (a) Except as provided by
19 Section 1701.005, an insurer may not use a document described by
20 Section 1701.002 in this state unless the form of the document is
21 filed with the department in accordance with this chapter.

22 (b) Except as provided by Section 1701.052, the insurer must
23 file the form of the document not later than the 60th day before the
24 date the document is used. (V.T.I.C. Art. 3.42, Secs. (a) (part),
25 (b) (part), (c) (part), (d) (part).)

26 Sec. 1701.052. FILE AND USE. (a) An insurer may use a
27 document described by Section 1701.002 immediately after the form

1 of the document is filed if the form, when filed, is accompanied by
2 a certification that meets the requirements of Subsection (b).

3 (b) The certification accompanying a form must:

4 (1) be signed by:

5 (A) an attorney licensed to practice law in this
6 state;

7 (B) an actuary familiar with the requirements of
8 this code and applicable rules adopted under this code;

9 (C) the chief executive officer of the insurer;
10 or

11 (D) an individual designated by the chief
12 executive officer of the insurer; and

13 (2) affirm that:

14 (A) the certification is made on behalf of the
15 insurer filing the form;

16 (B) the insurer is bound by the certification;

17 (C) the individual making the certification has
18 reviewed the form; and

19 (D) to the best knowledge, information, and
20 belief of the individual making the certification, the form
21 complies with this code and rules applicable to the form. (V.T.I.C.
22 Art. 3.42, Sec. (c) (part).)

23 Sec. 1701.053. FILING FEE. (a) The department shall
24 collect a fee in an amount determined by the commissioner for the
25 filing of the form of a document under this chapter.

26 (b) The fee may not exceed:

27 (1) \$100 for filing the form of a new or amended

document that is not exempt from review under Section 1701.005(b);
and

(2) \$50 for filing the form of a new or amended document that is exempt from review under Section 1701.005(b). (V.T.I.C. Art. 3.42, Secs. (e), (f) (part).)

Sec. 1701.054. APPROVAL OF FORM. (a) A form filed under this chapter that is not affirmatively approved or disapproved in a written order of the commissioner on or before the 60th day after the date the form is filed is considered approved on the 61st day after the date of filing unless the approval period is extended under this section.

(b) An insurer may request in writing that the approval period for a form be extended for an additional period not to exceed 45 days.

(c) An extension requested under this section is considered granted on the date the department receives the request.

(d) Only one extension may be granted under this section.

(e) If an extension is granted under this section and the commissioner does not affirmatively approve or disapprove the form before the extended period expires, the form is considered approved on the day after the date the extended period expires.

(f) If the commissioner approves a form that is filed without a certification meeting the requirements of Section 1701.052(b) before the expiration of the approval period, including any extension, the remaining portion of the period is waived. (V.T.I.C. Art. 3.42, Secs. (c) (part), (d) (part).)

Sec. 1701.055. DISAPPROVAL OF FORM OR WITHDRAWAL OF

1 APPROVAL OR EXEMPTION. (a) Except as provided by Subsection (d),
2 the commissioner may disapprove or, after notice and hearing,
3 withdraw approval of a form if the form:

4 (1) violates this code, a rule of the commissioner, or
5 any other law; or

6 (2) contains a provision, title, or heading that is
7 unjust, encourages misrepresentation, or is deceptive.

8 (b) A form filed under this chapter that contains a
9 coordination of benefits provision may not be approved for use in
10 this state unless the form provides for the order of benefits
11 determination for insured dependent children. An order of benefits
12 determination provision may not be approved if the provision:

13 (1) violates this code, a rule of the commissioner, or
14 any other law; or

15 (2) contains a provision, title, or heading that is
16 unjust, encourages misrepresentation, or is deceptive.

17 (c) If necessary to accomplish the purpose of Subsection
18 (b), the commissioner may adopt a policy provision and order the
19 inclusion of that provision in a document subject to that
20 subsection.

21 (d) If a form has been on file with the department for at
22 least 180 days and has previously been affirmatively approved by
23 the commissioner, been considered approved under this chapter, or
24 been exempted from the approval requirements under this chapter,
25 the commissioner may withdraw the approval or exemption only if:

26 (1) the form violates this code or a rule adopted under
27 this code; or

1 (2) the commissioner finds proof of gross
2 misrepresentation or fraud to a policyholder.

3 (e) An order of the commissioner disapproving or
4 withdrawing approval for a form must state the grounds for the
5 disapproval or withdrawal of approval and describe in adequate
6 detail the changes that are necessary to obtain approval.
7 (V.T.I.C. Art. 3.42, Secs. (g) (part), (i), (j), (o).)

8 Sec. 1701.056. USE OF DISAPPROVED FORM PROHIBITED. An
9 insurer who receives written notice that a form filed by the insurer
10 has been disapproved by the commissioner shall immediately stop
11 using the form. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

12 Sec. 1701.057. WITHDRAWAL OF INDIVIDUAL ACCIDENT AND HEALTH
13 INSURANCE POLICY FORM APPROVAL. (a) Except as provided by
14 Subsection (b), the commissioner may, after notice and hearing,
15 withdraw approval of an individual accident and health insurance
16 policy form if, after consideration of all relevant facts, the
17 commissioner determines that:

18 (1) the benefits provided under the form are
19 unreasonable in relation to the premium charged; or

20 (2) the reserve required by Section 862.102 is not
21 maintained by the insurer on the policies issued on the form.

22 (b) If an individual accident and health insurance policy
23 form has been on file with the department for at least 360 days and
24 has been affirmatively approved by the commissioner, been
25 considered approved under this chapter, or been exempted from the
26 approval requirements of this chapter, the commissioner may
27 withdraw the approval or exemption only if:

1 (1) the form violates this code or a rule adopted under
2 this code; or

3 (2) the commissioner finds proof of gross
4 misrepresentation or fraud to a policyholder.

5 (c) To enable the department to determine compliance with
6 Subsection (b), the commissioner:

7 (1) shall require an insurer to file the rates charged
8 by that insurer for individual accident and health insurance
9 policies; and

10 (2) may adopt and require an insurer to file in
11 conjunction with the annual statement required under Section
12 841.255, 982.101, or 982.103 a form for reporting the insurer's
13 experience on individual accident and health insurance policy forms
14 issued by the insurer.

15 (d) The commissioner shall, in accordance with Section
16 1201.007, adopt reasonable rules necessary to establish standards
17 under which the approval of an individual accident and health
18 insurance policy form may be withdrawn.

19 (e) This section does not grant the commissioner the
20 authority to determine, fix, prescribe, or promulgate rates to be
21 charged for an individual accident and health insurance policy.
22 (V.T.I.C. Art. 3.42, Secs. (k), (l), (m).)

23 Sec. 1701.058. RECONSIDERATION OF FORM. (a) Not later than
24 the 45th day after the date of an order of the commissioner
25 disapproving or withdrawing approval of a form under Section
26 1701.055, an insurer may correct the deficiencies described by the
27 order and file the corrected form with the department for

1 reconsideration by the commissioner.

2 (b) If the commissioner does not approve or disapprove a
3 form filed for reconsideration under this section on or before the
4 45th day after the date the form is filed, the form is considered
5 approved on the 46th day after the date the form is filed.
6 (V.T.I.C. Art. 3.42, Sec. (g) (part).)

7 Sec. 1701.059. REPLACEMENT OR AMENDMENT OF DOCUMENT. The
8 commissioner may order an insurer to replace a document described
9 by Section 1701.002 with a corrected document or to amend and
10 correct the document by endorsement or rider if:

11 (1) the commissioner disapproves or withdraws
12 approval of the form of the document under Section 1701.055(a); or

13 (2) the document is used before the form was approved
14 under this chapter and corrections must be made to the document to
15 bring the document into compliance with this code and rules of the
16 commissioner before the commissioner will approve the form of the
17 document. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

18 Sec. 1701.060. GENERAL RULEMAKING AUTHORITY. (a) The
19 commissioner may, within the standards and purposes of this
20 chapter, adopt reasonable rules necessary to implement this
21 chapter, including, after notice and hearing, rules that establish
22 procedures and criteria under which:

23 (1) each type of form submitted to the department
24 under this chapter will be reviewed and approved by the
25 commissioner or exempted under Section 1701.005(b); and

26 (2) particular types of forms designated by the
27 commissioner may be given a summary review and approval if

1 considered appropriate by the commissioner to expedite review and
2 approval of those forms.

3 (b) A rule adopted under this chapter may not be repealed or
4 amended before the first anniversary of the date the rule was
5 adopted unless the commissioner determines after notice and in a
6 public hearing that there is a compelling public need for the rule
7 to be repealed or amended. (V.T.I.C. Art. 3.42, Secs. (h) (part),
8 (p) (part).)

9 [Sections 1701.061-1701.100 reserved for expansion]

10 SUBCHAPTER C. SANCTIONS; APPLICABILITY OF OTHER LAWS

11 Sec. 1701.101. RESTITUTION. (a) The commissioner may
12 order an insurer to make complete restitution to each insured of
13 this state who is financially damaged by the insurer's use of a form
14 filed and used but not approved under this chapter if, after notice
15 and opportunity for hearing, the commissioner determines:

16 (1) the form does not comply with this code and the
17 rules of the commissioner;

18 (2) use of the form resulted in financial damage to an
19 insured of this state; and

20 (3) the insurer intentionally used the form with the
21 knowledge that it did not comply with this code and the rules of the
22 commissioner.

23 (b) The commissioner may determine the form and amount of
24 restitution ordered under this section and the period in which the
25 restitution must be made. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

26 Sec. 1701.102. LIMIT ON SANCTIONS. Except as provided by
27 Section 1701.101, the commissioner may not impose penalties or

1 other sanctions on an insurer for the issuance of a document the
2 form of which is filed under Section 1701.052. (V.T.I.C. Art. 3.42,
3 Sec. (c) (part).)

4 Sec. 1701.103. APPLICABILITY OF OTHER LAWS. Except as
5 provided by Section 1701.102, this chapter may not be construed to
6 limit the applicability of any other statute. (V.T.I.C. Art. 3.42,
7 Sec. (c) (part).)

8 [Sections 1701.104-1701.150 reserved for expansion]

9 SUBCHAPTER D. CERTAIN POLICY APPLICATION FORMS

10 Sec. 1701.151. POLICY APPLICATION FORM FOR INDIVIDUAL
11 ACCIDENT AND HEALTH POLICY. A policy application form that is
12 required to be or that is attached to an individual accident and
13 health policy shall comply with the rules of the commissioner
14 adopted under Chapter 1201. (V.T.I.C. Art. 3.42, Sec. (b) (part).)

15 SECTION 6. TITLE 11, INSURANCE CODE. The Insurance Code is
16 amended by adding Title 11 to read as follows:

17 TITLE 11. TITLE INSURANCE

18 SUBTITLE A. GENERAL PROVISIONS

19 CHAPTER 2501. GENERAL PROVISIONS

20 CHAPTER 2502. PROHIBITED CONDUCT

21 [Chapters 2503-2550 reserved for expansion]

22 SUBTITLE B. ORGANIZATION OF TITLE INSURANCE COMPANIES

23 CHAPTER 2551. TITLE INSURERS

24 CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES AND

25 TITLE ATTORNEYS

26 CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

27 [Chapters 2554-2600 reserved for expansion]

SUBTITLE C. FINANCIAL SOLVENCY

CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION,
REORGANIZATION, OR CONSERVATION OF TITLE
INSURANCE COMPANIES AND AGENTS

CHAPTER 2602. TEXAS TITLE INSURANCE GUARANTY ASSOCIATION
[Chapters 2603-2650 reserved for expansion]

SUBTITLE D. TITLE INSURANCE PROFESSIONALS

CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT
OPERATIONS

CHAPTER 2652. ESCROW OFFICERS
[Chapters 2653-2700 reserved for expansion]

SUBTITLE E. THE BUSINESS OF TITLE INSURANCE

CHAPTER 2701. GENERAL PROVISIONS

CHAPTER 2702. CLOSING AND SETTLEMENT

CHAPTER 2703. POLICY FORMS AND PREMIUM RATES

CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT;
DETERMINATION OF INSURABILITY

TITLE 11. TITLE INSURANCE

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 2501. GENERAL PROVISIONS

Sec. 2501.001. SHORT TITLE

Sec. 2501.002. PURPOSE; LEGISLATIVE INTENT

Sec. 2501.003. DEFINITIONS

Sec. 2501.004. ABSTRACT PLANT; JOINT ABSTRACT PLANT
OPERATION

Sec. 2501.005. BUSINESS OF TITLE INSURANCE

Sec. 2501.006. CLOSING THE TRANSACTION

1 Sec. 2501.007. REFERENCES TO TITLE

2 CHAPTER 2501. GENERAL PROVISIONS

3 Sec. 2501.001. SHORT TITLE. This title may be cited as the
4 Texas Title Insurance Act. (V.T.I.C. Art. 9.01, Sec. A.)

5 Sec. 2501.002. PURPOSE; LEGISLATIVE INTENT. (a) The
6 purpose of this title is to completely regulate the business of
7 title insurance, including the direct issuance of policies and the
8 reinsurance of any assumed risks, to:

9 (1) protect consumers and purchasers of title
10 insurance policies; and

11 (2) provide adequate and reasonable rates of return
12 for title insurance companies and title insurance agents.

13 (b) It is the express legislative intent that this title
14 accomplish the purpose described by Subsection (a). (V.T.I.C. Art.
15 9.01, Sec. B.)

16 Sec. 2501.003. DEFINITIONS. In this title:

17 (1) "Abstract plant" means an abstract plant as
18 defined by the department under Section 2501.004.

19 (2) "Attorney" means:

20 (A) a person who is licensed to practice law and
21 is a member of the State Bar of Texas; or

22 (B) a Texas professional corporation organized
23 to provide professional legal services.

24 (3) "Direct operation" means the operations of a title
25 insurance company under a license issued to the company under
26 Subchapter B, Chapter 2651. A reference in this title to a title
27 insurance agent shall be construed to include a direct operation

1 unless the context indicates otherwise.

2 (4) "Escrow officer" means an attorney, a bona fide
3 employee of an attorney licensed as an escrow officer, a bona fide
4 employee of a direct operation, or a bona fide employee of a title
5 insurance agent whose responsibilities include:

6 (A) countersigning title insurance forms;

7 (B) supervising the preparation and delivery of
8 title insurance forms;

9 (C) signing escrow checks; or

10 (D) closing the transaction, as described by
11 Section 2501.006.

12 (5) "Foreign title insurance company" means a title
13 insurance company organized under the laws of a jurisdiction other
14 than this state.

15 (6) "Joint abstract plant operation" means a joint
16 abstract plant operation as defined by the department under Section
17 2501.004.

18 (7) "Person" includes an individual, corporation,
19 association, partnership, or trust.

20 (8) "Premium" means the premium rates promulgated by
21 the commissioner under Subchapters D and E, Chapter 2703, and
22 includes a charge for:

23 (A) title examination and closing the
24 transaction, regardless of whether the examination or closing is
25 performed by an attorney; and

26 (B) issuing the policy.

27 (9) "Residential real property" means real property

1 that is improved and is designed principally for occupancy by one to
2 four families. The term includes an individual unit of a
3 condominium or cooperative.

4 (10) "Thing of value" includes any payment, advance,
5 funds, loan, service, or other consideration.

6 (11) "Title examination" means the search and
7 examination of a title to determine the conditions of the title to
8 be insured and to evaluate the risk to be undertaken in the issuance
9 of a title insurance policy or other title insurance form.

10 (12) "Title insurance" means:

11 (A) insurance that insures, guarantees, or
12 indemnifies an owner of real property, or another interested in the
13 real property, against loss or damage resulting from:

14 (i) a lien or encumbrance on or defect in
15 the title to the real property; or

16 (ii) the invalidity or impairment of a lien
17 on the real property; or

18 (B) any business that is substantially
19 equivalent to the insurance described by Paragraph (A) and is
20 conducted in a manner designed to evade the provisions of this
21 title.

22 (13) "Title insurance agent" means a person owning or
23 leasing and controlling an abstract plant or as a participant in a
24 bona fide joint abstract plant operation and authorized in writing
25 by a title insurance company to solicit insurance and collect
26 premiums and to issue or countersign policies on the company's
27 behalf.

(14) "Title insurance company" means:

(A) a domestic company organized under this title to engage in the business of title insurance, as described by Section 2501.005;

(B) a foreign title insurance company that:

(i) meets the requirements of this title; and

(ii) holds a certificate of authority to engage in business in this state; or

(C) any other domestic or foreign company that:

(i) meets the requirements of this title; and

(ii) holds a certificate of authority to insure a title to real property in this state. (V.T.I.C. Art. 9.02, Secs. (a), (c), (f) (part), (g), (h), (i) (part), (j), (k), (l), (m), (o), (p), (q); New.)

Sec. 2501.004. ABSTRACT PLANT; JOINT ABSTRACT PLANT OPERATION. (a) For purposes of this title, the department shall define "abstract plant" and "joint abstract plant operation."

(b) To provide for the safety and protection of policyholders, the department shall require that an abstract plant be:

(1) geographically arranged;

(2) kept current; and

(3) adequate for use in insuring titles, as determined by the department. (V.T.I.C. Art. 9.02, Secs. (f) (part), (i) (part).)

1 Sec. 2501.005. BUSINESS OF TITLE INSURANCE. (a) For
2 purposes of this title, a person engages in the business of title
3 insurance if the person:

4 (1) as insurer, guarantor, or surety, makes or
5 proposes to make a contract or policy of title insurance or its
6 equivalent;

7 (2) transacts or proposes to transact any phase of
8 title insurance, including:

9 (A) soliciting;

10 (B) title examination other than an examination
11 conducted by an attorney;

12 (C) closing the transaction other than a closing
13 conducted by an attorney;

14 (D) executing a contract of title insurance; and

15 (E) insuring and transacting matters arising out
16 of the contract after the contract is executed, including
17 reinsurance; or

18 (3) makes a guaranty or warranty of a title search or a
19 title examination, or any component of a title search or title
20 examination, if the person is not the person who performs the search
21 or examination.

22 (b) A person engages in the business of title insurance if
23 the person engages in or proposes to engage in any business that is
24 substantially equivalent to the business of title insurance as
25 described by this section, regardless of whether that conduct is
26 performed in a manner designed to evade the provisions of this
27 title. (V.T.I.C. Art. 9.02, Sec. (b).)

1 Sec. 2501.006. CLOSING THE TRANSACTION. (a) For purposes
2 of this title, "closing the transaction" describes the
3 investigation that is made:

4 (1) on behalf of a title insurance company, title
5 insurance agent, or direct operation before the title insurance
6 policy is issued; and

7 (2) to determine proper execution, acknowledgment,
8 and delivery of all conveyances, mortgage papers, and other title
9 instruments necessary to consummate a transaction.

10 (b) Closing the transaction includes a determination that:

11 (1) all delinquent taxes have been paid;

12 (2) in the case of an owner title insurance policy, all
13 current taxes, based on the latest available information, have been
14 properly prorated between the purchaser and seller;

15 (3) the consideration has been passed;

16 (4) all proceeds have been properly disbursed;

17 (5) a final search of the title has been made; and

18 (6) all necessary papers have been filed for record.

19 (V.T.I.C. Art. 9.02, Sec. (n).)

20 Sec. 2501.007. REFERENCES TO TITLE. In this title, a
21 reference to this title includes a reference to:

22 (1) Chapter 223;

23 (2) Chapter 271;

24 (3) Section 171.0527, Tax Code; and

25 (4) Subchapter U, Chapter 171, Tax Code. (New.)

26 CHAPTER 2502. PROHIBITED CONDUCT

27 SUBCHAPTER A. PROHIBITED CONDUCT IN GENERAL

1 Sec. 2502.001. ENGAGING IN CERTAIN INSURANCE BUSINESS

2 PROHIBITED

3 Sec. 2502.002. COVERAGE FOR UNMARKETABILITY OF TITLE

4 PROHIBITED

5 Sec. 2502.003. INSURING AROUND DEFINED; PROHIBITIONS AND

6 EXCEPTIONS

7 Sec. 2502.004. GUARANTEE OF MORTGAGE PAYMENT PROHIBITED

8 Sec. 2502.005. CIVIL PENALTY

9 [Sections 2502.006-2502.050 reserved for expansion]

10 SUBCHAPTER B. REBATES AND DISCOUNTS

11 Sec. 2502.051. REBATES AND DISCOUNTS PROHIBITED

12 Sec. 2502.052. CERTAIN DIVISIONS OF REAL PROPERTY CHARGES

13 PROHIBITED

14 Sec. 2502.053. CERTAIN COMPENSATORY PAYMENTS

15 NOT PROHIBITED

16 Sec. 2502.054. CERTAIN DIVISIONS OF PREMIUMS

17 NOT PROHIBITED

18 Sec. 2502.055. CERTAIN PROMOTIONAL AND EDUCATIONAL

19 ACTIVITIES NOT PROHIBITED

20 Sec. 2502.056. MONETARY FORFEITURE

21 CHAPTER 2502. PROHIBITED CONDUCT

22 SUBCHAPTER A. PROHIBITED CONDUCT IN GENERAL

23 Sec. 2502.001. ENGAGING IN CERTAIN INSURANCE BUSINESS

24 PROHIBITED. (a) A domestic or foreign corporation operating under
25 this title may not engage in the business of any kind of insurance
26 other than title insurance.

27 (b) A company may not engage in the business of title

1 insurance if the company engages in the business of another kind of
2 insurance. (V.T.I.C. Art. 9.09.)

3 Sec. 2502.002. COVERAGE FOR UNMARKETABILITY OF TITLE
4 PROHIBITED. (a) An insurance company may not insure against loss
5 or damage by reason of unmarketability of title.

6 (b) The commissioner may not adopt a rule or form providing
7 for coverage prohibited by this section. (V.T.I.C. Art. 9.09A.)

8 Sec. 2502.003. INSURING AROUND DEFINED; PROHIBITIONS AND
9 EXCEPTIONS. (a) Except as provided by Subsection (c), a title
10 insurance company may not wilfully issue a binder for title
11 insurance or a title insurance policy showing no outstanding
12 enforceable recorded liens on real property against which the
13 company knows an outstanding enforceable recorded lien exists.

14 (b) A title insurance company knows that an outstanding
15 enforceable recorded lien exists against real property if, based on
16 an examination of the title under which the binder for title
17 insurance or title insurance policy is issued, the company
18 determines that the lien is valid and enforceable.

19 (c) The commissioner by rule may approve circumstances
20 under which a title insurance company may issue a binder for title
21 insurance or a title insurance policy otherwise prohibited by
22 Subsection (a).

23 (d) Except as otherwise provided by this section, a title
24 insurance company may determine the insurability of title to real
25 property and any other matter that the company considers to be
26 insurable under a binder for title insurance or a title insurance
27 policy issued in connection with the property. (V.T.I.C. Art. 9.08

(part).)

Sec. 2502.004. GUARANTEE OF MORTGAGE PAYMENT PROHIBITED.

(a) A title insurance company may not guarantee the payment of a mortgage on real property.

(b) A title insurance company that violates this section forfeits its authority to engage in business in this state and shall immediately surrender its certificate of authority. (V.T.I.C. Art. 9.08 (part).)

Sec. 2502.005. CIVIL PENALTY. (a) A person is liable to the state for a civil penalty of not more than \$5,000 if the person:

(1) wilfully violates Section 2502.003 or 2502.004; or

(2) violates an order of the commissioner refusing to approve an application to issue a binder for title insurance or a title insurance policy prohibited by Section 2502.003(a).

(b) The department may bring an action in a Travis County district court to recover the penalty provided by this section. (V.T.I.C. Art. 9.08 (part).)

[Sections 2502.006-2502.050 reserved for expansion]

SUBCHAPTER B. REBATES AND DISCOUNTS

Sec. 2502.051. REBATES AND DISCOUNTS PROHIBITED. A commission, rebate, discount, portion of a title insurance premium, or other thing of value may not be directly or indirectly paid, allowed, or permitted by a person engaged in the business of title insurance or received or accepted by a person for engaging in the business of title insurance or for soliciting or referring title insurance business. (V.T.I.C. Art. 9.30, Sec. A.)

Sec. 2502.052. CERTAIN DIVISIONS OF REAL PROPERTY CHARGES

1 PROHIBITED. Other than for services actually performed, a person
2 may not give or accept any portion, split, or percentage of a charge
3 made or received for a settlement or closing performed in
4 connection with a transaction involving the conveyance or
5 mortgaging of real property located in this state. (V.T.I.C. Art.
6 9.30, Sec. E.)

7 Sec. 2502.053. CERTAIN COMPENSATORY PAYMENTS NOT
8 PROHIBITED. This subchapter does not prohibit:

9 (1) payment for services actually performed by a title
10 insurance company, title insurance agent, or direct operation in
11 connection with title examination or with closing the transaction
12 or furnishing title evidence if:

13 (A) the payment does not exceed the percentage of
14 premium or other amount established by the commissioner for the
15 payment; and

16 (B) the person receiving the payment is licensed
17 as provided by this title;

18 (2) payment of bona fide compensation to a bona fide
19 employee principally employed by a title insurance company, title
20 insurance agent, or direct operation;

21 (3) reasonable payment for goods or facilities
22 actually provided and received; or

23 (4) payment for services actually performed by an
24 attorney in connection with title examination or with closing the
25 transaction, if the payment does not exceed a reasonable charge for
26 the services. (V.T.I.C. Art. 9.30, Secs. B (part), C.)

27 Sec. 2502.054. CERTAIN DIVISIONS OF PREMIUMS NOT

1 PROHIBITED. (a) For purposes of this section, a subsidiary is a
2 company at least 50 percent of the voting stock of which is owned by
3 the title insurance company or by a wholly owned subsidiary of the
4 title insurance company.

5 (b) This subchapter does not:

6 (1) prohibit a title insurance company from:

7 (A) appointing as its title insurance agent for a
8 county a person who owns or leases and operates an abstract plant
9 for that county; and

10 (B) arranging for a division of premiums with the
11 agent as set by the commissioner; or

12 (2) affect the division of a premium between a title
13 insurance company and its subsidiary title insurance agent when the
14 company directly issues a title insurance policy or contract under
15 Section 2704.002. (V.T.I.C. Art. 9.30, Sec. B (part).)

16 Sec. 2502.055. CERTAIN PROMOTIONAL AND EDUCATIONAL
17 ACTIVITIES NOT PROHIBITED. This subchapter does not prohibit legal
18 promotional and educational activities that are not conditioned on
19 the referral of title insurance business. (V.T.I.C. Art. 9.30,
20 Sec. B (part).)

21 Sec. 2502.056. MONETARY FORFEITURE. (a) A person who pays
22 or receives a commission, rebate, discount, or other thing of value
23 for soliciting or referring title insurance business in violation
24 of Section 2502.051 is engaging in the unauthorized business of
25 insurance.

26 (b) After notice and opportunity for hearing, a person who
27 makes or receives a payment described by Subsection (a) is liable

1 for a monetary forfeiture in an amount not less than the value of or
2 more than three times the value of the payment.

3 (c) A monetary forfeiture under Subsection (b) is in
4 addition to any other penalty provided by law. (V.T.I.C. Art. 9.30,
5 Sec. D.)

6 [Chapters 2503-2550 reserved for expansion]

7 SUBTITLE B. ORGANIZATION OF TITLE INSURANCE COMPANIES

8 CHAPTER 2551. TITLE INSURERS

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Sec. 2551.001. APPLICABILITY OF TITLE AND OTHER LAW

11 Sec. 2551.002. APPLICABILITY OF LAW GOVERNING

12 CORPORATIONS

13 Sec. 2551.003. RULEMAKING; AUTHORITY OF DEPARTMENT AND

14 COMMISSIONER

15 [Sections 2551.004-2551.050 reserved for expansion]

16 SUBCHAPTER B. FORMATION

17 Sec. 2551.051. FORMATION; GENERAL PURPOSES AND POWERS

18 Sec. 2551.052. NAME

19 Sec. 2551.053. STOCK AND SURPLUS REQUIREMENTS

20 Sec. 2551.054. PURCHASE OF OWN STOCK

21 Sec. 2551.055. CHARTER OF CORPORATION ENGAGING IN BUSINESS

22 OF TITLE INSURANCE

23 Sec. 2551.056. REGULATION OF CERTAIN CORPORATIONS

24 [Sections 2551.057-2551.100 reserved for expansion]

25 SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

26 Sec. 2551.101. CERTIFICATE OF AUTHORITY REQUIRED

27 Sec. 2551.102. ISSUANCE OF CERTIFICATE OF AUTHORITY

[Sections 2551.103-2551.150 reserved for expansion]

SUBCHAPTER D. GENERAL POWERS AND DUTIES

Sec. 2551.151. ADMISSIBLE INVESTMENTS

Sec. 2551.152. ANNUAL STATEMENT

Sec. 2551.153. FEES

Sec. 2551.154. TRANSFER OF CERTAIN BUSINESS TO STATE

BANKS OR TRUST COMPANIES

[Sections 2551.155-2551.200 reserved for expansion]

SUBCHAPTER E. REQUIRED DEPOSIT

Sec. 2551.201. DEPOSIT REQUIRED; AMOUNT

Sec. 2551.202. EXCEPTION: FOREIGN TITLE INSURANCE COMPANY

Sec. 2551.203. WITHDRAWAL AND SUBSTITUTION OF DEPOSIT

Sec. 2551.204. USE OF DEPOSIT

[Sections 2551.205-2551.250 reserved for expansion]

SUBCHAPTER F. RESERVES

Sec. 2551.251. STATUTORY PREMIUM RESERVE REQUIRED

Sec. 2551.252. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEAR

1997; REDUCTIONS

Sec. 2551.253. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEARS

AFTER 1997; REDUCTIONS

Sec. 2551.254. TRANSITIONAL RELEASE; TRANSITIONAL CHARGE

Sec. 2551.255. RUNOFF BALANCE

Sec. 2551.256. ACTUARIAL CERTIFICATION

Sec. 2551.257. SUPPLEMENTAL RESERVE

Sec. 2551.258. REEVALUATION OF CERTAIN RESERVE

REQUIREMENTS

Sec. 2551.259. STATUTORY PREMIUM RESERVE AND SUPPLEMENTAL

RESERVE FUND

Sec. 2551.260. EFFECT OF INSOLVENCY OR DISSOLUTION

Sec. 2551.261. RESERVE FOR UNPAID LOSSES AND LOSS

EXPENSES

[Sections 2551.262-2551.300 reserved for expansion]

SUBCHAPTER G. LIABILITY AND REINSURANCE

Sec. 2551.301. MAXIMUM POLICY LIABILITY

Sec. 2551.302. REQUIREMENTS FOR REINSURING POLICIES

Sec. 2551.303. FORM OF REINSURANCE CONTRACT

Sec. 2551.304. ACCEPTANCE OF REINSURANCE

Sec. 2551.305. CERTAIN REINSURANCE ALLOWED

[Sections 2551.306-2551.350 reserved for expansion]

SUBCHAPTER H. ENFORCEMENT AND INTERVENTION

Sec. 2551.351. FORFEITURE OF RIGHT TO ENGAGE IN BUSINESS

Sec. 2551.352. REVOCATION OF PERMIT AND FORFEITURE

OF CHARTER

Sec. 2551.353. PROCEDURE FOR REVOCATION OF CERTIFICATE

Sec. 2551.354. APPEAL OF COMMISSIONER ACTION

CHAPTER 2551. TITLE INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2551.001. APPLICABILITY OF TITLE AND OTHER LAW. (a)

Except as provided by Subsection (c) and unless the business of title insurance or title insurance companies are expressly mentioned, the provisions of this code other than this title do not apply to:

(1) a corporation incorporated or engaging in business exclusively under this title; or

1 (2) any title insurance business engaged in by a
2 corporation created under:

3 (A) Subdivision 57, Article 1302, Revised
4 Statutes;

5 (B) Chapter 861; or

6 (C) any other law.

7 (b) A law enacted after September 7, 1951, does not apply to
8 a title insurance company or title insurance business described by
9 Subsection (a) unless the law expressly states that it applies.

10 (c) To the extent applicable, the following provisions of
11 this code apply to a title insurance company:

12 (1) Articles 1.01, 1.04A, 1.09-1, 1.12, 1.13,
13 1.15-1.19, 21.31, 21.47, and 21.49-8;

14 (2) Subsection (b), Article 1.04D;

15 (3) Article 1.14-3, other than Section 8;

16 (4) Subchapter F, Chapter 5;

17 (5) Chapters 33, 82, 83, 84, 102, 261, 281, 541, 547,
18 555, 701, 801, 802, 824, and 828;

19 (6) Chapter 31, other than Section 31.005;

20 (7) Chapter 32, other than Section 32.022(b);

21 (8) Chapter 36, other than Sections 36.003, 36.004,
22 and 36.101-36.106;

23 (9) Subchapter A, Chapter 38;

24 (10) Subchapters A-G, Chapter 101;

25 (11) Chapter 982, other than Sections 982.003,
26 982.051, 982.101, 982.105, 982.106(b), 982.109, and 982.113; and

27 (12) Sections 37.052, 39.001, 39.002, 81.002, 81.004,

1 201.004, 201.005, 201.051, 201.055, 521.002-521.004, 805.021,
2 822.001, 822.051, 822.052(1), (2), and (3), 822.053, 822.057,
3 except Subsection (a)(4), 822.058, 822.059, 822.060, 822.155,
4 822.157, 822.158, except Subsection (a)(5), 841.004, 841.251,
5 841.252(a)-(c), and 4001.103.

6 (d) This title governs in any conflict between a provision
7 listed by Subsection (c) and a provision of this title.

8 (e) This title does not regulate the practice of law by an
9 attorney. The actions of an attorney in examining title or in
10 closing a real property transaction, regardless of whether a title
11 insurance policy is issued, does not constitute the business of
12 title insurance, unless the attorney elects to be licensed as an
13 escrow officer.

14 (f) Subsection (e) does not prohibit the commissioner from
15 promulgating a premium for title insurance. (V.T.I.C. Art. 9.22,
16 Sec. (b); Art. 9.47, Secs. 1, 2, 3.)

17 Sec. 2551.002. APPLICABILITY OF LAW GOVERNING
18 CORPORATIONS. A title insurance company is subject to the Texas
19 Business Corporation Act, the Texas Miscellaneous Corporation Laws
20 Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), and
21 any other law of this state that governs corporations in general, to
22 the extent those laws are not inconsistent with this title.
23 (V.T.I.C. Art. 9.04.)

24 Sec. 2551.003. RULEMAKING; AUTHORITY OF DEPARTMENT AND
25 COMMISSIONER. (a) The commissioner may adopt and enforce rules:

26 (1) that prescribe underwriting standards and
27 practices on which a title insurance contract must be issued;

1 (2) that define risks that may not be assumed under a
2 title insurance contract, including risks that may not be assumed
3 because of the insolvency of the parties to the transaction; and

4 (3) that the commissioner determines are necessary to
5 accomplish the purposes of this title.

6 (b) With respect to a company operating under this title
7 that engages in the kinds of business described by Section
8 2551.051(b)(1) or (2) in a manner that might subject the company to
9 another regulatory statute of this state, all examination and
10 regulation shall be exercised by the department rather than any
11 other state agency named in the other regulatory statute, as long as
12 the corporation engages in the business of title insurance.
13 (V.T.I.C. Art. 9.21.)

14 [Sections 2551.004-2551.050 reserved for expansion]

15 SUBCHAPTER B. FORMATION

16 Sec. 2551.051. FORMATION; GENERAL PURPOSES AND POWERS. (a)
17 A private corporation may be created and licensed under this title
18 for the following purposes:

19 (1) to compile and own or lease, or to acquire and own
20 or lease, records or abstracts of title to real property or
21 interests in real property in this state or other jurisdictions, to
22 insure titles to that real property or interests in that real
23 property, and to indemnify the owners of that real property, or the
24 holders of interests in or liens on that real property, against loss
25 or damage resulting from an encumbrance on or defect in the title to
26 the real property or interests in the real property; and

27 (2) in transactions in which title insurance is to be

1 or is being issued, to supervise or approve the signing of legal
2 instruments affecting real property titles, disbursement of money,
3 prorations, delivery of legal instruments, closing of
4 transactions, or issuance of commitments for title insurance
5 specifying the requirements for title insurance and the defects in
6 title necessary to be cured or corrected.

7 (b) A corporation described by Subsection (a) may exercise
8 any of the following powers by including the power in the
9 corporation's charter:

10 (1) to make and sell abstracts of title in any county
11 of this state or another state;

12 (2) to accumulate and lend money and to purchase, sell
13 or deal in notes, bonds, and securities, but without banking
14 privileges;

15 (3) to act as trustee under a lawful trust committed to
16 the corporation by contract or will or by appointment by a court as
17 trustee, receiver, or guardian; and

18 (4) to act as executor or guardian under the terms of a
19 will or as an administrator of a decedent's estate under the
20 appointment of a court.

21 (c) Notwithstanding any other provision of this section, a
22 corporation described by Subsection (a) is not authorized to
23 practice law, as that term is defined by the courts of this state. A
24 corporation described by Subsection (a) is not authorized to
25 prepare a legal instrument described by Subsection (a)(2).
26 (V.T.I.C. Art. 9.03.)

27 Sec. 2551.052. NAME. (a) The name of a corporation

1 chartered or operating under this title may contain the words
2 "Title and Trust Company."

3 (b) The name of a corporation chartered or operating under
4 this title may not contain the word "Trust" alone. If the word
5 "Trust" appears in the corporation's letterhead or literature, the
6 corporation shall include the words "Without Banking Privileges."
7 (V.T.I.C. Art. 9.23.)

8 Sec. 2551.053. STOCK AND SURPLUS REQUIREMENTS. (a) Except
9 as provided by Section 2552.053(b), a title insurance company must
10 have a paid-up capital of at least \$1 million and a surplus of at
11 least \$1 million.

12 (b) The capital stock and minimum surplus requirements of a
13 title insurance company must be maintained intact over and above
14 all outstanding liabilities, except contingent liabilities on
15 title insurance policies.

16 (c) If a title insurance company suffers the impairment of
17 its capital stock or minimum surplus requirements, the company
18 shall immediately report the impairment to the department.
19 (V.T.I.C. Arts. 9.06, 9.20.)

20 Sec. 2551.054. PURCHASE OF OWN STOCK. (a) Subject to
21 Section 2551.053(a) and the Texas Business Corporation Act, a title
22 insurance company may purchase its own shares of stock. A purchase
23 of its own shares is not considered an investment and does not
24 constitute a violation of a provision of this code relating to
25 admissible investments.

26 (b) A title insurance company that purchases its own shares
27 must, not later than the 10th day after the date of purchase, file

1 with the commissioner a statement listing:

2 (1) the name of each shareholder from whom the shares
3 have been purchased; and

4 (2) the amount paid for the shares. (V.T.I.C. Art.
5 9.06A.)

6 Sec. 2551.055. CHARTER OF CORPORATION ENGAGING IN BUSINESS
7 OF TITLE INSURANCE. (a) The incorporators of a corporation
8 engaging in the business of title insurance and incorporated under
9 this title, Subdivision 57, Article 1302, Revised Statutes, Chapter
10 40, Acts of the 41st Legislature, Regular Session, 1929 (Article
11 1302a, Vernon's Texas Civil Statutes), or any other law shall file
12 the corporation's original charter only with the department and
13 shall certify the charter only to the department.

14 (b) Only the department may collect from a company described
15 by this section any filing fees required by law.

16 (c) A corporation described by this section is not subject
17 to another law to the extent that the law conflicts with this
18 section. (V.T.I.C. Art. 9.14.)

19 Sec. 2551.056. REGULATION OF CERTAIN CORPORATIONS. (a) A
20 corporation incorporated under Subdivision 57, Article 1302,
21 Revised Statutes, before February 27, 1929, and engaging in
22 business in this state on February 27, 1929:

23 (1) may continue to engage in business;

24 (2) is subject to this title; and

25 (3) shall comply with the requirements of this title
26 regarding investments and deposits.

27 (b) A shareholder in a company acting under this title is

1 not liable in the event of default in the payment of any debt or
2 liability of the company beyond the shareholder's subscription for
3 stock. (V.T.I.C. Art. 9.32.)

4 [Sections 2551.057-2551.100 reserved for expansion]

5 SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

6 Sec. 2551.101. CERTIFICATE OF AUTHORITY REQUIRED. A title
7 insurance company may not engage in the business of title insurance
8 in this state unless the company holds a certificate of authority
9 issued under this title. (V.T.I.C. Art. 9.15 (part).)

10 Sec. 2551.102. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a)
11 Subject to Subsection (c), the department shall issue a certificate
12 of authority to engage in the business of title insurance if,
13 following any examination the department considers proper, the
14 department makes a determination favorable to the title insurance
15 company with respect to:

16 (1) the payment of capital stock and surplus as
17 required by this title; and

18 (2) the value of the assets used to pay the capital
19 stock and surplus.

20 (b) The title insurance company shall pay the expense of any
21 examination conducted under Subsection (a).

22 (c) Issuance of a certificate of authority to a foreign
23 corporation is governed by Section 2553.001. (V.T.I.C. Art. 9.15
24 (part); New.)

25 [Sections 2551.103-2551.150 reserved for expansion]

26 SUBCHAPTER D. GENERAL POWERS AND DUTIES

27 Sec. 2551.151. ADMISSIBLE INVESTMENTS. (a) A title

1 insurance company shall hold all investments in cash or in the
2 following:

3 (1) an abstract plant or plants, provided that:

4 (A) the corporation is organized under this title
5 and has the right to engage in the business of title insurance;

6 (B) except as provided by Subsection (b), the
7 investment is not more than 50 percent of the corporation's capital
8 stock; and

9 (C) the valuation of the plant or plants is
10 approved by the department;

11 (2) securities described by Article 3.39 or
12 investments authorized for title insurance companies under the laws
13 of any other state in which the company is authorized to engage in
14 business;

15 (3) real property or any real property interest that
16 is:

17 (A) required for the company's convenient
18 accommodation in the transaction of business with reasonable regard
19 to future needs;

20 (B) acquired in connection with a claim under a
21 title insurance policy;

22 (C) acquired in satisfaction or on account of
23 loans, mortgages, liens, judgments, or decrees previously owed to
24 the company in the course of business;

25 (D) acquired in partial payment of the
26 consideration of the sale of real property owned by the company if
27 the transaction results in a net reduction in the company's

1 investment in real property; or

2 (E) reasonably necessary to maintain or enhance
3 the sale value of real property previously acquired or held by the
4 company under this subdivision;

5 (4) a first mortgage note secured by any of the
6 following, provided that the amount of the note does not exceed 80
7 percent of the appraised value of the security for the note:

8 (A) an abstract plant and connected personal
9 property in or outside this state;

10 (B) stock of a title insurance agent in or
11 outside this state;

12 (C) a construction contract to build an abstract
13 plant and connected personal property; or

14 (D) any two or more of the items listed in this
15 subdivision;

16 (5) the shares of any federal home loan bank in an
17 amount necessary to qualify for membership and any additional
18 amounts approved by the commissioner;

19 (6) foreign securities that are substantially of the
20 same kinds, classes, and investment grade as securities otherwise
21 qualified for investment under this section, provided that, unless
22 the investment is also qualified under Subdivision (2), the
23 aggregate amount of foreign investments made under this subdivision
24 does not exceed:

25 (A) five percent of the insurer's admitted assets
26 at the end of the preceding year;

27 (B) two percent of the insurer's admitted assets

1 at the end of the preceding year invested in the securities of all
2 entities domiciled in any one foreign country; and

3 (C) one-half of one percent of the insurer's
4 admitted assets at the end of the preceding year invested in the
5 securities of any one individual entity domiciled in a foreign
6 country;

7 (7) securities lending, repurchase, reverse
8 repurchase, and dollar roll transactions, as described by Section
9 4(q), Article 3.33; or

10 (8) money market funds, as described by Section 4(s),
11 Article 3.33.

12 (b) If a corporation maintains with the department a deposit
13 described by Subchapter E in the amount of \$100,000, the
14 corporation may invest more than 50 percent of the corporation's
15 capital stock under Subsection (a)(1), as considered necessary by
16 the corporation's board of directors.

17 (c) A corporation created or operating under this title may
18 own or acquire more than one abstract plant in any one county, but
19 only one abstract plant in any one county is admissible as an
20 investment under Subsection (a)(1).

21 (d) A title insurance company may not hold real property
22 acquired under Subsection (a)(3)(B), (C), or (D) for more than 10
23 years without written approval of the department.

24 (e) Any investment that does not qualify under this section
25 and was owned by the title insurance company on October 1, 1967,
26 continues to qualify.

27 (f) If any otherwise valid investment qualified under this

1 section exceeds in amount any of the limitations on investment
2 provided by this section, the investment is inadmissible only to
3 the extent that it exceeds the limitation. (V.T.I.C. Art. 9.18.)

4 Sec. 2551.152. ANNUAL STATEMENT. (a) Not later than March
5 1 of each year, each title insurance company shall file with the
6 commissioner a verified statement.

7 (b) The statement must be in a form required by the
8 commissioner and must:

9 (1) provide a statement of the business engaged in by
10 the title insurance company during the preceding year; and

11 (2) describe the condition of the company's affairs on
12 December 31 of the preceding year. (V.T.I.C. Art. 9.22, Sec. (a).)

13 Sec. 2551.153. FEES. The general laws applicable to
14 payment of a filing fee by a corporation having capital stock apply
15 to a corporation subject to this title. (V.T.I.C. Art. 9.13.)

16 Sec. 2551.154. TRANSFER OF CERTAIN BUSINESS TO STATE BANKS
17 OR TRUST COMPANIES. (a) This section applies to a corporation
18 chartered under Section 2551.051, or its antecedents, Article 9.01,
19 Texas Insurance Code, or Chapter 40, Acts of the 41st Legislature,
20 Regular Session, 1929 (Article 1302a, Vernon's Texas Civil
21 Statutes), and empowered to act as:

22 (1) trustee under a lawful trust committed to the
23 corporation by contract or will or by appointment by a court as
24 trustee, receiver, or guardian; and

25 (2) executor or guardian under the terms of a will or
26 as an administrator of a decedent's estate under the appointment of
27 the court.

1 (b) A corporation described by Subsection (a) may transfer
2 and assign to one of the following entities all of the corporation's
3 fiduciary business in which the corporation is named or acts as
4 guardian, trustee, executor, or administrator or in any other
5 fiduciary capacity:

6 (1) a state bank created under Subtitle A, Title 3,
7 Finance Code, or a predecessor to that law; or

8 (2) a state trust company created under Chapter 181,
9 Finance Code, or a predecessor to that law.

10 (c) On a corporation's transfer or assignment to a state
11 bank or trust company under this section, the state bank or trust
12 company shall, without the necessity of any action in a court of
13 this state or any action by the creator or beneficiary of the trust
14 or estate:

15 (1) continue the guardianship, trust, executorship,
16 administration, or other fiduciary relationship related to the
17 trust or estate;

18 (2) perform all of the duties and obligations of the
19 corporation related to the trust or estate; and

20 (3) exercise any powers and authority:

21 (A) related to the trust or estate; and

22 (B) exercised by the corporation at the time of
23 the transfer or assignment.

24 (d) A transfer or assignment by a corporation under this
25 section is not a resignation or refusal by the corporation to act on
26 behalf of the guardianship, trust, executorship, administration,
27 or other fiduciary relationship.

1 (e) On a corporation's transfer or assignment to a state
2 bank or trust company under this section, the naming or designation
3 by a testator or the creator of a living trust of the corporation to
4 act as trustee, guardian, or executor or in any other fiduciary
5 capacity includes the naming or designation of the state bank or
6 trust company and authorizes the state bank or trust company to act
7 in that capacity. (V.T.I.C. Art. 9.05, Sec. 1 (part).)

8 [Sections 2551.155-2551.200 reserved for expansion]

9 SUBCHAPTER E. REQUIRED DEPOSIT

10 Sec. 2551.201. DEPOSIT REQUIRED; AMOUNT. (a) Except as
11 provided by Section 2551.202, a title insurance company shall
12 deposit and maintain in the state treasury, or other depository in
13 this state named by the company and approved by the department,
14 either:

15 (1) cash; or

16 (2) securities described by Section 2551.151.

17 (b) A title insurance company's deposit under this section
18 must be in an amount equal to the lesser of:

19 (1) one-fourth of the authorized capital of the
20 company; or

21 (2) \$100,000.

22 (c) A deposit under this section is for the benefit of all
23 policyholders. (V.T.I.C. Art. 9.12 (part).)

24 Sec. 2551.202. EXCEPTION: FOREIGN TITLE INSURANCE COMPANY.

25 (a) A foreign title insurance company is not required to make a
26 deposit under Section 2551.201 if the company has on deposit with
27 insurance regulatory bodies in the United States an aggregate

1 amount of deposit that:

2 (1) is equal to the amount required by Section
3 2551.201; and

4 (2) secures all policyholders of the company,
5 regardless of their location.

6 (b) The foreign title insurance company must file with the
7 department a certificate of deposit under the hand and seal of each
8 insurance regulatory body holding a deposit of the company.
9 (V.T.I.C. Art. 9.12 (part).)

10 Sec. 2551.203. WITHDRAWAL AND SUBSTITUTION OF DEPOSIT. A
11 title insurance company may withdraw the deposit of securities made
12 under Section 2551.201, or any portion of the deposit, after
13 substituting other securities of a sufficient value to maintain the
14 amount of deposit required under that section. (V.T.I.C. Art. 9.12
15 (part).)

16 Sec. 2551.204. USE OF DEPOSIT. (a) Except as otherwise
17 provided by Subsection (e), a deposit made under this subchapter
18 may be used only to pay an obligation connected with title
19 insurance.

20 (b) On the insolvency or dissolution of a title insurance
21 company, the company's deposit shall be used to protect title
22 insurance policyholders even if no accrued title insurance claims
23 exist and other unpaid obligations do exist, except as permitted by
24 Subsection (e).

25 (c) A title insurance company's deposit must be applied to:

26 (1) the complete payment of any obligations and
27 liabilities of the company connected with title insurance business;

1 and

2 (2) the establishment of adequate reserves or
3 reinsurance to protect any subsequently accruing or maturing title
4 insurance obligations and liabilities.

5 (d) The amount, handling, and distribution of any reserves
6 required under Subsection (c)(2) are subject to the control and
7 discretion of the department and are reviewable in judicial
8 proceedings governed by rules applicable to review of rates under
9 Subchapters D and E, Chapter 2703.

10 (e) Any deposit amount remaining after payments under
11 Subsection (c) must be applied to:

12 (1) payment of other obligations and liabilities of
13 the title insurance company; or

14 (2) distribution to shareholders. (V.T.I.C. Art. 9.12
15 (part).)

16 [Sections 2551.205-2551.250 reserved for expansion]

17 SUBCHAPTER F. RESERVES

18 Sec. 2551.251. STATUTORY PREMIUM RESERVE REQUIRED. (a)
19 Each domestic title insurer shall establish and maintain a
20 statutory premium reserve. The reserve is cumulative. The reserve
21 must consist of the amounts required under Sections
22 2551.252-2551.260 and must be established and maintained during the
23 period and for the uses and purposes provided by those sections.

24 (b) The reserve required under this section:

25 (1) is considered to be unearned portions of the
26 original premium; and

27 (2) must be charged as a reserve liability of the title

insurer in determining the insurer's financial condition.
(V.T.I.C. Art. 9.16, Sec. 1.)

Sec. 2551.252. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEAR 1997; REDUCTIONS. (a) The total charges of a domestic title insurer for title insurance policies written or assumed on or after January 1, 1997, and before January 1, 1998, are computed by adding the following, as described in the insurer's annual statement:

(1) the direct premium written by the insurer;

(2) the escrow and settlement service fees paid directly to and collected by the insurer;

(3) other title fees and service charges paid directly to and collected by the insurer, including fees for closing protection letters; and

(4) premiums for any reinsurance assumed by the insurer, less premiums for reinsurance ceded by the insurer during that year.

(b) The amount a domestic title insurer must set aside in the statutory premium reserve for the 1997 calendar year is computed by multiplying the total charges computed under Subsection (a) by:

(1) 6-1/5 percent if the insurer had \$250 million or more in direct premium written for the year 1996; or

(2) 3-1/2 percent if the insurer had less than \$250 million in direct premium written for the year 1996.

(c) A domestic title insurer shall reduce additions to the statutory premium reserve set aside for title insurance policies written or assumed during the year 1997 over a 20-year period

beginning in the year after the year in which the policies are written or assumed, as provided by Subsection (d), by:

(1) 26 percent of the additions in the first year following the year of addition;

(2) 20 percent of the additions in the second year following the year of addition;

(3) 10 percent of the additions in the third year following the year of addition;

(4) nine percent of the additions in the fourth year following the year of addition;

(5) five percent of the additions in the fifth and sixth years following the year of addition;

(6) three percent of the additions in the seventh, eighth, and ninth years following the year of addition;

(7) two percent of the additions in the 10th through 14th years following the year of addition; and

(8) one percent of the additions in the last six years of the 20-year period.

(d) A domestic title insurer shall make the annual reductions under Subsection (c) in increments of one-fourth of the appropriate percentage of the additions each on March 31, June 30, September 30, and December 31 of each year. (V.T.I.C. Art. 9.16, Sec. 2.)

Sec. 2551.253. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEARS AFTER 1997; REDUCTIONS. (a) Out of total charges for title insurance policies written or assumed on or after January 1, 1998, a domestic title insurer shall add to and set aside in the statutory

1 premium reserve an amount equal to the total of the following, as
2 described in the insurer's annual statement:

3 (1) 25 cents per \$1,000 of net retained liability if
4 the insurer had \$250 million or more in direct written premiums
5 written for the most recent calendar year; or

6 (2) 30 cents per \$1,000 of net retained liability if
7 the insurer had less than \$250 million in direct written premiums
8 written for the most recent calendar year.

9 (b) A domestic title insurer shall reduce additions to the
10 statutory premium reserve set aside for title insurance policies
11 written or assumed after the year 1997 over a 20-year period
12 beginning in the year after the year in which the policies are
13 written or assumed in the manner and under the same percentages
14 applied under Sections 2551.252(c) and (d). (V.T.I.C. Art. 9.16,
15 Sec. 3.)

16 Sec. 2551.254. TRANSITIONAL RELEASE; TRANSITIONAL CHARGE.

17 (a) In addition to the requirements described by Sections 2551.252
18 and 2551.253, each domestic title insurer shall compute a total
19 statutory premium reserve balance for all policy years combined as
20 of December 31, 1996.

21 (b) A domestic title insurer shall compute the balance under
22 Subsection (a) as if Section 2551.252 were in effect during the
23 20-year period ending December 31, 1996. That balance, less the
24 total actual statutory premium reserve balance carried by the
25 insurer on December 31, 1996, is the insurer's transitional charge
26 if the resulting amount is more than zero or is the insurer's
27 transitional release if the resulting amount is zero or less.

1 (c) If a domestic title insurer has a transitional charge
2 under Subsection (b), in addition to any changes to the statutory
3 premium reserve otherwise required by this subchapter, the insurer
4 shall add to its statutory premium reserve, on December 31 of each
5 year for 10 consecutive years beginning on December 31, 1997, an
6 amount equal to one-tenth of the transitional charge.

7 (d) If a domestic title insurer has a transitional release
8 under Subsection (b), in addition to any changes to the statutory
9 premium reserve otherwise required by this subchapter, the insurer
10 shall reduce its statutory premium reserve, on December 31 of each
11 year for 10 consecutive years beginning on December 31, 1997, by an
12 amount equal to one-tenth of the transitional release. (V.T.I.C.
13 Art. 9.16, Sec. 4.)

14 Sec. 2551.255. RUNOFF BALANCE. (a) At the end of each
15 calendar year beginning in 1997, each domestic title insurer shall
16 compute a total statutory premium reserve balance for all policy
17 years before January 1, 1997, combined. The balance shall be
18 computed as of the year-end evaluation date and as if Section
19 2551.252 were in effect during the 20-year period ending December
20 31, 1996. The balance computed under this subsection is the runoff
21 balance.

22 (b) A domestic title insurer shall reduce its statutory
23 premium reserve by an amount equal to the difference between:

24 (1) the runoff balance computed under Subsection (a);
25 and

26 (2) the runoff balance computed for the preceding
27 calendar year.

1 (c) The reduction of the statutory premium reserve under
2 Subsection (b) is in addition to any other changes to the statutory
3 premium reserve required by this subchapter. (V.T.I.C. Art. 9.16,
4 Sec. 5.)

5 Sec. 2551.256. ACTUARIAL CERTIFICATION. (a) Each domestic
6 or foreign title insurer shall file annually with the insurer's
7 annual statement required under Section 2551.152 an actuarial
8 certification made by a member in good standing of the American
9 Academy of Actuaries.

10 (b) An actuarial certification must:

11 (1) conform to the annual statement instructions for a
12 title insurer adopted by the National Association of Insurance
13 Commissioners; and

14 (2) include the actuary's professional opinion of the
15 insurer's reserves as of the date of the annual statement.

16 (c) The reserves analyzed under this section must include
17 reserves for known claims, including adverse development on known
18 claims, and reserves for incurred but not reported claims.
19 (V.T.I.C. Art. 9.16, Secs. 6, 8 (part).)

20 Sec. 2551.257. SUPPLEMENTAL RESERVE. Each domestic or
21 foreign title insurer shall establish a supplemental reserve in an
22 amount equal to the amount by which the actuarially certified
23 reserves exceed the total of the known claim reserve and statutory
24 premium reserve as set forth in the insurer's annual statement
25 required under Section 2551.152. (V.T.I.C. Art. 9.16, Secs. 7(a),
26 8 (part).)

27 Sec. 2551.258. REEVALUATION OF CERTAIN RESERVE

1 REQUIREMENTS. The commissioner may reevaluate the adequacy of the
2 statutory premium reserves required under Section 2551.253 and may
3 make recommendations for legislative changes as the commissioner
4 considers appropriate. (V.T.I.C. Art. 9.16, Sec. 9.)

5 Sec. 2551.259. STATUTORY PREMIUM RESERVE AND SUPPLEMENTAL
6 RESERVE FUND. The statutory premium reserve and supplemental
7 reserve fund shall be:

8 (1) held in cash; or

9 (2) invested in first mortgage notes or other
10 securities admissible for investment by title insurers under
11 Section 2551.151. (V.T.I.C. Art. 9.16, Sec. 10.)

12 Sec. 2551.260. EFFECT OF INSOLVENCY OR DISSOLUTION. On the
13 insolvency or dissolution of a title insurer, the statutory premium
14 reserve and supplemental reserve fund shall be used to protect
15 title insurance policyholders, even if no accrued title insurance
16 claims exist and other unpaid obligations do exist. (V.T.I.C. Art.
17 9.16, Sec. 11.)

18 Sec. 2551.261. RESERVE FOR UNPAID LOSSES AND LOSS EXPENSES.
19 (a) A title insurance company shall establish and maintain, in
20 addition to any other reserves, a reserve against:

21 (1) unpaid losses; and

22 (2) loss expense for costs of defense of an insured and
23 other costs expected to be paid to other parties in the defense,
24 settlement, or processing of a claim under the terms of a title
25 insurance policy.

26 (b) A title insurance company shall compute the amount of
27 the reserve required by this section by carefully estimating any

1 loss and loss expense likely to be incurred on a proper disposition
2 of each claim presented, under notice from or on behalf of the
3 insured, of a title defect in or lien or adverse claim against a
4 title insured by the company.

5 (c) The total expenses of the title insurance company are
6 equal to the estimate under Subsection (b) for payment of loss and
7 costs of defense of the insured and other costs expected to be paid
8 to other parties in the defense, settlement, or processing of the
9 claim under the terms of the title insurance policy. The title
10 insurance company shall revise the estimate at least annually and
11 may additionally revise the estimate as circumstances warrant.

12 (d) The amounts set aside in the reserve in any year shall be
13 deducted in determining the net profits for that year of any title
14 insurance company. (V.T.I.C. Art. 9.17.)

15 [Sections 2551.262-2551.300 reserved for expansion]

16 SUBCHAPTER G. LIABILITY AND REINSURANCE

17 Sec. 2551.301. MAXIMUM POLICY LIABILITY. (a) Except as
18 provided by Subsection (b), a title insurance company may not issue
19 a title insurance policy on any real property located in this state
20 involving a potential policy liability of more than 50 percent of
21 the company's capital stock and surplus as stated in the most recent
22 annual statement of the company.

23 (b) A title insurance company may exceed the limit described
24 by Subsection (a) if the excess liability is reinsured in due course
25 in an authorized title insurance company. (V.T.I.C. Art. 9.19,
26 Sec. A (part).)

27 Sec. 2551.302. REQUIREMENTS FOR REINSURING POLICIES. A

1 title insurance company may reinsure any of its policies and
2 contracts issued on real property located in this state, if:

3 (1) the reinsuring title insurance company is
4 authorized to engage in business in this state under this title; and

5 (2) the department first approves the form of the
6 reinsurance contract. (V.T.I.C. Art. 9.19, Sec. A (part).)

7 Sec. 2551.303. FORM OF REINSURANCE CONTRACT. (a) If the
8 department approves a form of reinsurance contract for a title
9 insurance company, the company may continue using the form without
10 submitting individual reinsurance contracts to the department for
11 approval.

12 (b) The department may alter the required form of a
13 reinsurance contract previously approved by the department after
14 first giving written notice to each title insurance company
15 affected by the alteration. (V.T.I.C. Art. 9.19, Sec. B.)

16 Sec. 2551.304. ACCEPTANCE OF REINSURANCE. A title
17 insurance company may accept a reinsurance risk on real property
18 located in this state only from an authorized title insurance
19 company. (V.T.I.C. Art. 9.19, Sec. C.)

20 Sec. 2551.305. CERTAIN REINSURANCE ALLOWED. (a)
21 Notwithstanding any other provision of this subchapter, the
22 department may, on application and hearing, permit a title
23 insurance company to acquire reinsurance on an individual policy or
24 facultative basis from a title insurance company not authorized to
25 engage in the business of title insurance in this state, if:

26 (1) the company has exhausted the opportunity to
27 acquire reinsurance from all other authorized title insurance

1 companies; and

2 (2) the title insurance company from which the
3 reinsurance is acquired has a combined capital and surplus of at
4 least \$1.4 million as stated in its annual statement preceding the
5 acceptance of reinsurance.

6 (b) Notwithstanding any other provision of this subchapter,
7 the department may, on application and hearing, permit a title
8 insurance company, including an authorized reinsuring title
9 insurance company, to retain an additional potential liability of
10 not more than 40 percent of the company's capital stock and surplus
11 as stated in the most recent annual statement of the company, if:

12 (1) the company has exhausted the opportunity to
13 acquire reinsurance under Subsection (a); and

14 (2) the additional potential liability of the company
15 is incurred only if the loss suffered by the insured under the
16 policy exceeds the amount of insurance and reinsurance accepted by
17 the company and its reinsuring title insurance companies under the
18 other provisions of this subchapter. (V.T.I.C. Art. 9.19, Secs. D,
19 E.)

20 [Sections 2551.306-2551.350 reserved for expansion]

21 SUBCHAPTER H. ENFORCEMENT AND INTERVENTION

22 Sec. 2551.351. FORFEITURE OF RIGHT TO ENGAGE IN BUSINESS.

23 (a) A foreign or domestic corporation forfeits any right to engage
24 in business in this state if the corporation:

25 (1) issues any form of title insurance policy, or any
26 other adopted or approved form, on real property in this state other
27 than a form prescribed by the department;

1 (2) charges any premium rate on an owner, mortgagee,
2 or other title insurance policy, or on any other adopted or approved
3 form, on real property in this state other than a premium rate
4 prescribed by the commissioner; or

5 (3) otherwise engages in the business of title
6 insurance in relation to real property in this state on a form or
7 for a premium rate not prescribed by the department or
8 commissioner.

9 (b) This section does not apply to a premium rate charged in
10 connection with a reinsurance transaction between two or more title
11 insurance companies, provided that the reinsurance contract
12 complies with Subchapter G. (V.T.I.C. Art. 9.11.)

13 Sec. 2551.352. REVOCATION OF PERMIT AND FORFEITURE OF
14 CHARTER. (a) A domestic corporation engaged in the business of
15 title insurance that violates this title is subject to:

16 (1) revocation by the commissioner of the
17 corporation's permit; and

18 (2) forfeiture of the corporation's charter.

19 (b) A foreign corporation engaged in the business of title
20 insurance that violates this title is subject to revocation by the
21 commissioner of the corporation's permit. (V.T.I.C. Art. 9.33,
22 Sec. (a).)

23 Sec. 2551.353. PROCEDURE FOR REVOCATION OF CERTIFICATE.

24 (a) If the commissioner determines that a domestic or foreign
25 corporation that holds a certificate of authority to engage in
26 business in this state has violated this title, the commissioner
27 shall notify the company that the commissioner intends to revoke

1 the company's certificate of authority on the expiration of the
2 30-day period following the date actual notice is delivered or
3 mailed under this section.

4 (b) Notice under this section must:

5 (1) be in writing; and

6 (2) be delivered to an executive officer of the
7 company by personal service or by registered mail.

8 (c) If a company receiving notice under this section does
9 not fully comply before the expiration of the period described by
10 Subsection (a), the commissioner shall revoke the company's
11 certificate of authority.

12 (d) A company whose certificate of authority is revoked
13 under this section is ineligible for another certificate of
14 authority until the later of:

15 (1) the date on which the company fully and in good
16 faith complies; or

17 (2) the first anniversary of the date of the
18 revocation. (V.T.I.C. Art. 9.28 (part).)

19 Sec. 2551.354. APPEAL OF COMMISSIONER ACTION. (a) A
20 company qualified or seeking to qualify under this title and
21 aggrieved by an action of the commissioner, including any action
22 against the company, may file an appeal of the commissioner's
23 action in a district court in Travis County.

24 (b) The appeal must be filed not later than the 30th day
25 after the date the commissioner issues the order or ruling, except
26 that if the order or ruling is directed against the company, whether
27 or not directed against any other party, the company has 30 days

1 after the date of receipt of official notice of the commissioner's
2 action to review the action.

3 (c) An appeal under this section is subject to the same
4 standard of review as an appeal under this code in accordance with
5 Section 36.203. (V.T.I.C. Art. 9.33, Sec. (b).)

6 CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES
7 AND TITLE ATTORNEYS

8 SUBCHAPTER A. GENERAL PROVISIONS

9 Sec. 2552.001. PURPOSE; LEGISLATIVE INTENT

10 Sec. 2552.002. DEFINITIONS

11 Sec. 2552.003. APPLICABILITY OF TITLE 11

12 Sec. 2552.004. BUSINESS OF ATTORNEY'S TITLE INSURANCE

13 Sec. 2552.005. OTHER TITLE INSURANCE COMPANIES AND AGENTS

14 PROHIBITED

15 Sec. 2552.006. RECORD OF TITLE ATTORNEYS

16 Sec. 2552.007. OTHER PREMIUM OR FEE PROHIBITED

17 [Sections 2552.008-2552.050 reserved for expansion]

18 SUBCHAPTER B. ORGANIZATION OF ATTORNEY'S TITLE
19 INSURANCE COMPANY

20 Sec. 2552.051. ORGANIZING MEMBERS

21 Sec. 2552.052. CAPITAL SHARE AND SURPLUS REQUIREMENTS

22 GENERALLY

23 Sec. 2552.053. CAPITAL SHARE AND SURPLUS REQUIREMENTS

24 FOR STATE BAR ENTITY

25 Sec. 2552.054. REACQUISITION OF SHARES

26 Sec. 2552.055. REACQUISITION PLAN REQUIRED

27 Sec. 2552.056. INAPPLICABILITY OF LAWS REGULATING

SECURITIES

[Sections 2552.057-2552.100 reserved for expansion]

SUBCHAPTER C. TITLE ATTORNEY'S LICENSE AND RENEWAL

Sec. 2552.101. LICENSE AND OTHER GENERAL REQUIREMENTS

Sec. 2552.102. LICENSE APPLICATION

Sec. 2552.103. LICENSE ISSUANCE AND DELIVERY

Sec. 2552.104. DUPLICATE LICENSE

Sec. 2552.105. LICENSE TERM

Sec. 2552.106. AUTOMATIC TERMINATION OF LICENSE

Sec. 2552.107. LICENSE SURRENDER OR FORFEITURE

Sec. 2552.108. CONTINUATION OF LICENSE

[Sections 2552.109-2552.150 reserved for expansion]

SUBCHAPTER D. TITLE ATTORNEY GENERAL REQUIREMENTS

Sec. 2552.151. CONTRACT REQUIRED FOR APPOINTMENT

Sec. 2552.152. ABSTRACT PLANT REQUIREMENTS

Sec. 2552.153. CONTRACT WITH LICENSED ABSTRACT PLANT

Sec. 2552.154. BOND OR DEPOSIT REQUIRED

Sec. 2552.155. EXAMINATION OF LOSS COVERED BY BOND

Sec. 2552.156. INVESTIGATION BY ATTORNEY GENERAL

Sec. 2552.157. AUTHORITY TO ISSUE POLICY

Sec. 2552.158. AUTHORITY TO DELIVER BUT NOT ISSUE

POLICY

[Sections 2552.159-2552.200 reserved for expansion]

SUBCHAPTER E. POWERS AND DUTIES OF ATTORNEY'S

TITLE INSURANCE COMPANIES

Sec. 2552.201. ACTING AS TITLE ATTORNEY

Sec. 2552.202. LIST OF TITLE ATTORNEYS

1 Sec. 2552.203. RENEWAL

2 Sec. 2552.204. NOTICE OF TERMINATION

3 [Sections 2552.205-2552.250 reserved for expansion]

4 SUBCHAPTER F. AUDIT AND EXAMINATION REQUIREMENTS

5 RELATING TO TRUST FUND ACCOUNTS

6 Sec. 2552.251. ANNUAL AUDIT

7 Sec. 2552.252. ANALYSIS OF ANNUAL AUDIT

8 Sec. 2552.253. EXAMINATION OF TRUST FUND ACCOUNTS;

9 TRANSACTION REPORTS

10 Sec. 2552.254. ENFORCEMENT; HEARING

11 [Sections 2552.255-2552.300 reserved for expansion]

12 SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

13 Sec. 2552.301. GROUNDS FOR LICENSE DENIAL OR

14 DISCIPLINARY ACTION

15 Sec. 2552.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL, OR

16 REVOCATION

17 CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES

18 AND TITLE ATTORNEYS

19 SUBCHAPTER A. GENERAL PROVISIONS

20 Sec. 2552.001. PURPOSE; LEGISLATIVE INTENT. (a) Except as
21 otherwise expressly provided by this chapter, the purpose of this
22 chapter is to regulate an attorney's title insurance company in the
23 same manner as a title insurance company engaged in the business of
24 title insurance under this title.

25 (b) It is the express intent of the legislature to achieve
26 the purpose described by Subsection (a). (V.T.I.C. Art. 9.56, Sec.
27 1(d).)

1 Sec. 2552.002. DEFINITIONS. In this chapter:

2 (1) "Attorney's title insurance" means:

3 (A) insurance that:

4 (i) insures, guarantees, or indemnifies an
5 owner of real property in this state, or another interested in the
6 real property, against loss or damage resulting from:

7 (a) a lien or encumbrance on or defect
8 in the title to the real property; or

9 (b) the invalidity of a lien on the
10 real property; and

11 (ii) is issued only in connection with and
12 as part of a real property transaction and a title opinion of a
13 title attorney; or

14 (B) any business that is substantially
15 equivalent to the insurance business described by Paragraph (A) and
16 is conducted in a manner designed to evade the provisions of this
17 title.

18 (2) "Attorney's title insurance company" means a
19 domestic company organized and operated in accordance with this
20 chapter for the business of attorney's title insurance.

21 (3) "Title attorney" means an attorney who satisfies
22 the requirements of this chapter to act as a title attorney in this
23 state for an attorney's title insurance company. (V.T.I.C. Art.
24 9.56, Secs. 1(a), 2(a), (c), (d) (part), 3 (part); New.)

25 Sec. 2552.003. APPLICABILITY OF TITLE 11. Except as
26 otherwise expressly provided by this chapter:

27 (1) this title applies to an attorney's title

1 insurance company;

2 (2) the provisions of this title that apply to a title
3 insurance company also apply to an attorney's title insurance
4 company;

5 (3) the provisions of this title that apply to a title
6 insurance agent also apply to a title attorney; and

7 (4) any rule adopted or premium promulgated by the
8 commissioner under this title applies to an attorney's title
9 insurance company and to a title attorney. (V.T.I.C. Art. 9.56,
10 Secs. 1(b), (c).)

11 Sec. 2552.004. BUSINESS OF ATTORNEY'S TITLE INSURANCE. (a)
12 The business of attorney's title insurance may be engaged in only by
13 an attorney's title insurance company through a title attorney
14 appointed by an attorney's title insurance company.

15 (b) For purposes of this chapter, a person engages in the
16 business of attorney's title insurance if the person:

17 (1) as insurer, guarantor, or surety, makes or
18 proposes to make a contract or policy of title insurance; or

19 (2) transacts or proposes to transact any phase of
20 title insurance, including:

21 (A) soliciting;

22 (B) negotiating before executing a title
23 insurance contract;

24 (C) executing a contract of title insurance; and

25 (D) insuring and transacting matters arising out
26 of the contract after the contract is executed, including
27 reinsurance.

1 (c) A person engages in the business of attorney's title
2 insurance if the person engages in or proposes to engage in any
3 business that is substantially equivalent to the business of
4 attorney's title insurance as part of a real property transaction
5 and title opinion of a title attorney in a manner designed to evade
6 the applicable provisions of this title. (V.T.I.C. Art. 9.56,
7 Secs. 2(b), 12 (part).)

8 Sec. 2552.005. OTHER TITLE INSURANCE COMPANIES AND AGENTS
9 PROHIBITED. A title insurance company, title insurance agent, or
10 escrow officer of a title insurance agent licensed under this title
11 to engage in the business of title insurance in this state may not
12 operate as an attorney's title insurance company or act as a title
13 attorney under this chapter. (V.T.I.C. Art. 9.56, Sec. 12 (part).)

14 Sec. 2552.006. RECORD OF TITLE ATTORNEYS. The department
15 shall maintain a record of the name and address of each title
16 attorney in a manner that allows a person on request to conveniently
17 ascertain and inspect the title attorneys appointed by an
18 attorney's title insurance company authorized to engage in the
19 business of attorney's title insurance in this state. (V.T.I.C.
20 Art. 9.56, Sec. 6(b) (part).)

21 Sec. 2552.007. OTHER PREMIUM OR FEE PROHIBITED. Attorney's
22 title insurance may not be issued for any premium or fee other than
23 the applicable prescribed premium as provided by Subchapters D and
24 E, Chapter 2703. (V.T.I.C. Art. 9.56, Sec. 3 (part).)

25 [Sections 2552.008-2552.050 reserved for expansion]

26 SUBCHAPTER B. ORGANIZATION OF ATTORNEY'S TITLE INSURANCE COMPANY

27 Sec. 2552.051. ORGANIZING MEMBERS. Fifteen or more members

1 of the State Bar of Texas who are residents of this state may
2 organize a private corporation to act as an attorney's title
3 insurance company. (V.T.I.C. Art. 9.56, Sec. 3 (part).)

4 Sec. 2552.052. CAPITAL SHARE AND SURPLUS REQUIREMENTS
5 GENERALLY. (a) At the time of organization, an attorney's title
6 insurance company must have the capital and surplus required of a
7 title insurance company under Section 2551.053(a).

8 (b) The capital shares of an attorney's title insurance
9 company may be issued for a par value of \$100 or more per share and
10 in one or more classes.

11 (c) The capital shares, regardless of class, must be
12 subscribed and paid for and owned by and issued to licensed members
13 of the State Bar of Texas, each of whom is a resident of this state
14 and is qualified to be appointed a title attorney under this
15 chapter, subject to the right of reacquisition under Section
16 2552.054.

17 (d) Each certificate evidencing any share must have
18 endorsed on the certificate provisions relating to limitation on
19 the alienation of the shares indicating that the shares may be owned
20 only by qualifying attorneys or the attorney's title insurance
21 company issuing the shares.

22 (e) The requirements prescribed by Subsections (a), (c),
23 and (d) do not apply to an attorney's title insurance company
24 described by Section 2552.053 or to capital shares of an attorney's
25 title insurance company owned under that section. (V.T.I.C. Art.
26 9.56, Secs. 3 (part), 4(b), 13(b).)

27 Sec. 2552.053. CAPITAL SHARE AND SURPLUS REQUIREMENTS FOR

1 STATE BAR ENTITY. (a) An association of the organized State Bar of
2 Texas, the State Bar of Texas, or any foundation created by or
3 through the State Bar of Texas, the purposes of which include the
4 continuing legal education of the bench and bar of this state, may
5 own any class of capital shares of an attorney's title insurance
6 company if, at all times, at least 15 members of the State Bar of
7 Texas who are residents of this state own capital shares, whether or
8 not of the same class, in the attorney's title insurance company.

9 (b) An attorney's title insurance company created as an
10 affiliate or subsidiary of the organized State Bar of Texas, the
11 State Bar of Texas, or any foundation created by or through the
12 State Bar of Texas must have a paid-up capital of at least \$250,000
13 and a surplus of at least \$150,000. (V.T.I.C. Art. 9.56, Secs. 3
14 (part), 4(a).)

15 Sec. 2552.054. REACQUISITION OF SHARES. (a) The capital
16 shares of an attorney's title insurance company are subject to the
17 right of reacquisition of the shares by the attorney's title
18 insurance company in the event of:

- 19 (1) the death of the attorney shareholder;
20 (2) the failure of the attorney shareholder to remain
21 a licensed member of the State Bar of Texas; or
22 (3) the failure of the attorney shareholder to remain
23 appointed and qualified to be appointed a title attorney under this
24 chapter.

25 (b) An attorney's title insurance company must reacquire a
26 deceased attorney shareholder's shares within nine months of the
27 attorney shareholder's death. (V.T.I.C. Art. 9.56, Secs. 3 (part),

1 13(d).)

2 Sec. 2552.055. REACQUISITION PLAN REQUIRED. (a) As part of
3 the application for the approval of the charter of an attorney's
4 title insurance company, the applicants must file with the
5 department an acceptable plan providing for the reacquisition of
6 all shares of stock of the attorney's title insurance company
7 issued to a qualified attorney when the attorney is no longer
8 qualified to own the shares or on the death of the attorney.

9 (b) The plan must be approved by the department.

10 (c) In addition to other provisions, the plan must include
11 an express provision that the attorney's title insurance company
12 may not reacquire under any circumstance outstanding shares of its
13 stock as treasury stock if the reacquisition will result in
14 reducing its capital and surplus below the minimum capital and
15 surplus required for the initial organization of the attorney's
16 title insurance company. (V.T.I.C. Art. 9.56, Sec. 13(c).)

17 Sec. 2552.056. INAPPLICABILITY OF LAWS REGULATING
18 SECURITIES. (a) All state laws, other than this title, that
19 provide for supervision, registration, or regulation in connection
20 with the sale, issuance, or offering of securities do not apply to
21 the sale, issuance, or offering of any capital stock to a person
22 authorized under this chapter to own the capital stock.

23 (b) The sale, issuance, or offering of any stock described
24 by this section is legal without any action or approval by any
25 official or state regulatory agency authorized to license,
26 regulate, or supervise the sale, issuance, or offering of
27 securities. (V.T.I.C. Art. 9.56, Sec. 13(a).)

[Sections 2552.057-2552.100 reserved for expansion]

SUBCHAPTER C. TITLE ATTORNEY'S LICENSE AND RENEWAL

Sec. 2552.101. LICENSE AND OTHER GENERAL REQUIREMENTS. To act as a title attorney in this state for an attorney's title insurance company, an attorney must:

(1) be a member in good standing of the State Bar of Texas;

(2) own one or more shares of stock in the attorney's title insurance company by which the attorney is appointed;

(3) be actively engaged in the practice of law;

(4) meet the requirements prescribed by this chapter regarding an abstract plant;

(5) be appointed by an attorney's title insurance company as its title attorney authorized by the attorney's title insurance company to solicit insurance, collect premiums, and issue or countersign policies on behalf of the attorney's title insurance company;

(6) be certified as a title attorney to the department;

(7) hold a license issued by the department under this subchapter; and

(8) maintain a surety bond or deposit as required by Section 2552.154. (V.T.I.C. Art. 9.56, Secs. 2(d) (part), 5 (part).)

Sec. 2552.102. LICENSE APPLICATION. (a) Before an initial license is issued to an attorney to act as a title attorney in this state for an attorney's title insurance company, the attorney's

1 title insurance company must file an application for a title
2 attorney's license with the department on forms provided by the
3 department.

4 (b) The application must be:

5 (1) accompanied by a nonrefundable fee in an amount
6 not to exceed \$50 as prescribed by the department; and

7 (2) signed and sworn to by the attorney's title
8 insurance company and the proposed title attorney.

9 (c) The completed application must state that:

10 (1) the proposed title attorney:

11 (A) is a licensed attorney in this state and a
12 resident of this state;

13 (B) is actively engaged in the practice of law;

14 (C) is known to the attorney's title insurance
15 company:

16 (i) to have a good business reputation;

17 (ii) to be a current member, in good
18 standing, of the State Bar of Texas; and

19 (iii) to be worthy of the public trust; and

20 (D) meets the qualifications for a title attorney
21 as prescribed by this chapter; and

22 (2) the attorney's title insurance company does not
23 know of any fact or condition that would disqualify the proposed
24 title attorney from receiving a license. (V.T.I.C. Art. 9.56, Sec.
25 6(a) (part).)

26 Sec. 2552.103. LICENSE ISSUANCE AND DELIVERY. (a) The
27 department shall issue a title attorney's license if the department

1 determines, based on the application and the department's
2 investigation, that the requirements of Section 2552.102 are
3 satisfied.

4 (b) The department shall deliver the license to the
5 attorney's title insurance company for transmittal to the title
6 attorney. (V.T.I.C. Art. 9.56, Secs. 6(a) (part), (b) (part).)

7 Sec. 2552.104. DUPLICATE LICENSE. (a) The department
8 shall collect in advance a fee from a license holder who requests a
9 duplicate title attorney's license.

10 (b) The department shall prescribe the fee in an amount not
11 to exceed \$20. (V.T.I.C. Art. 9.56, Sec. 6(a) (part).)

12 Sec. 2552.105. LICENSE TERM. Unless a system of staggered
13 renewal is adopted under Section 4003.002, a title attorney's
14 license expires on June 1 following the date of issuance. (V.T.I.C.
15 Art. 9.56, Sec. 6(b) (part).)

16 Sec. 2552.106. AUTOMATIC TERMINATION OF LICENSE. The
17 license of each title attorney appointed by an attorney's title
18 insurance company that surrenders its certificate of authority or
19 has its certificate revoked by the department is automatically
20 terminated without notice. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

21 Sec. 2552.107. LICENSE SURRENDER OR FORFEITURE. (a) A
22 title attorney may voluntarily surrender the title attorney's
23 license at any time by giving notice to the department and to the
24 attorney's title insurance company.

25 (b) A title attorney automatically forfeits the title
26 attorney's license under the attorney's title insurance company if
27 the title attorney terminates the title attorney's relationship

1 with the attorney's title insurance company.

2 (c) A surrender or forfeiture of a title attorney's license
3 under this section does not affect the culpability of the license
4 holder for conduct committed before the effective date of the
5 surrender or forfeiture. The department may institute a
6 disciplinary proceeding against the former license holder for
7 conduct committed before the effective date of the surrender or
8 forfeiture. (V.T.I.C. Art. 9.56, Secs. 8(a), (f).)

9 Sec. 2552.108. CONTINUATION OF LICENSE. (a) Not later than
10 the 30th day after the date an attorney's title insurance company
11 terminates its contract with a title attorney or gives notice of
12 termination to the title attorney, the title attorney may apply to
13 the department for continuation of the title attorney's license.

14 (b) The application must include an amendment to the license
15 stating the name of another attorney's title insurance company for
16 which the title attorney is or will be authorized to act. (V.T.I.C.
17 Art. 9.56, Sec. 6(c).)

18 [Sections 2552.109-2552.150 reserved for expansion]

19 SUBCHAPTER D. TITLE ATTORNEY GENERAL REQUIREMENTS

20 Sec. 2552.151. CONTRACT REQUIRED FOR APPOINTMENT. (a) A
21 title attorney must be appointed by an attorney's title insurance
22 company by contract.

23 (b) The contract must make arrangements for division of
24 premium as may be approved by the department under this title.
25 (V.T.I.C. Art. 9.56, Sec. 2(d) (part).)

26 Sec. 2552.152. ABSTRACT PLANT REQUIREMENTS. (a) A title
27 attorney must:

1 (1) own or lease and control a licensed abstract
2 plant;

3 (2) participate in a bona fide joint abstract plant
4 operation;

5 (3) contract in accordance with this subchapter to
6 obtain title evidence from a licensed abstract plant; or

7 (4) use title evidence provided by an approved
8 abstract plant owned or leased and controlled by the attorney's
9 title insurance company.

10 (b) If at the time of applying for a license under Section
11 2552.102 an attorney does not own or lease and control a licensed
12 abstract plant, is not a participant in a bona fide joint abstract
13 plant operation, and is unable to contract to obtain title evidence
14 from a licensed abstract plant located in the county in which the
15 attorney resides, the attorney, as part of the license application,
16 may satisfy the requirements of this section by filing with the
17 department on a form prescribed by the department a disclosure of
18 the inability to obtain the contract. (V.T.I.C. Art. 9.56, Sec.
19 2(d) (part).)

20 Sec. 2552.153. CONTRACT WITH LICENSED ABSTRACT PLANT. (a)
21 A title attorney may enter into a contract with a licensed abstract
22 plant under which the abstract plant provides title evidence to the
23 title attorney. The contract must:

24 (1) be on a form prescribed by the commissioner; and

25 (2) state the standards for the evidence to be
26 provided.

27 (b) The commissioner may change the form of the contract.

1 (c) The parties to the contract shall determine the portion
2 of the premium to be paid by the title attorney to the licensed
3 abstract plant, subject to approval by the department.

4 (d) The department may disapprove any division of the
5 premium that the department determines to be excessive or
6 inadequate. The contract is considered to be approved as to the
7 division of the premium until the parties are notified of
8 disapproval by the department.

9 (e) The portion of the premium to be paid to the licensed
10 abstract plant is considered to be in compliance with Section
11 2502.053(1).

12 (f) The parties to the contract shall file with the
13 department a copy of the contract not later than the 10th day after
14 the date of execution of the contract. (V.T.I.C. Art. 9.56, Secs.
15 2(d) (part), 7(b).)

16 Sec. 2552.154. BOND OR DEPOSIT REQUIRED. (a) A title
17 attorney shall make, file, and pay for a surety bond payable to the
18 department in the amount of \$7,500 and issued by a corporate surety
19 company authorized to write surety bonds in this state. The bond
20 shall obligate the principal and surety to pay any pecuniary loss
21 that is incurred by:

22 (1) a participant in a real property settlement or
23 closing in which an attorney's title insurance policy is issued by
24 the title attorney and that is sustained through an act of fraud,
25 dishonesty, theft, embezzlement, or wilful misapplication by a
26 title attorney; and

27 (2) any party to an escrow agreement in which the title

1 attorney is escrowee and that is sustained through an act of fraud,
2 dishonesty, forgery, theft, embezzlement, or wilful misapplication
3 by the title attorney, either directly and alone or in conspiracy
4 with another person.

5 (b) Instead of a surety bond, a title attorney may deposit
6 with the department cash or securities approved by the department
7 in the amount of \$7,500, subject to the same conditions required for
8 the bond. (V.T.I.C. Art. 9.56, Sec. 9(a).)

9 Sec. 2552.155. EXAMINATION OF LOSS COVERED BY BOND. (a) At
10 any time it appears that the terms of a title attorney's bond may
11 have been violated, the department may require the title attorney
12 to appear in Travis County, with records the department determines
13 to be proper, for an examination.

14 (b) The department shall specify a date for the examination
15 that is not earlier than the 10th day or later than the 15th day
16 after the date of service of notice of the requirement to appear.

17 (c) If after the examination the department determines that
18 the terms of the bond have been violated, the department shall
19 immediately notify the surety and prepare a written statement of
20 the facts of the loss and deliver the statement to the attorney
21 general. (V.T.I.C. Art. 9.56, Sec. 9(b) (part).)

22 Sec. 2552.156. INVESTIGATION BY ATTORNEY GENERAL. (a) On
23 receipt of a written statement under Section 2552.155, the attorney
24 general shall investigate the charges and, on determining that the
25 terms of the bond have been violated, shall enforce the liability
26 against cash or securities or by filing suit on the bond.

27 (b) A suit brought under this section shall be filed in the

1 name of the department in Travis County for the benefit of all
2 parties who have suffered any loss because of the violation.
3 (V.T.I.C. Art. 9.56, Sec. 9(b) (part).)

4 Sec. 2552.157. AUTHORITY TO ISSUE POLICY. A title attorney
5 may issue a title insurance policy for an attorney's title
6 insurance company only if the title attorney:

7 (1) is appointed by the attorney's title insurance
8 company as its title attorney;

9 (2) bases each title opinion on separate and current
10 title evidence, provided by a licensed abstract plant, of the
11 records of the county in which the real property, the title to which
12 is to be insured, is located; and

13 (3) pays to the licensed abstract plant the portion of
14 the premium agreed to by the title attorney and the abstract plant
15 and approved by the department, if the title attorney contracts to
16 obtain the title evidence from the abstract plant as provided by
17 Section 2552.153. (V.T.I.C. Art. 9.56, Sec. 7(a).)

18 Sec. 2552.158. AUTHORITY TO DELIVER BUT NOT ISSUE POLICY. A
19 title attorney may deliver, but not issue, a title insurance policy
20 in conformity with Subchapter A, Chapter 2704, if:

21 (1) the title attorney does not own or lease and
22 control a licensed abstract plant, is not a participant in a bona
23 fide joint abstract plant operation, and is unable to contract with
24 a licensed abstract plant to obtain the required title evidence in
25 the county in which the real property, the title to which is to be
26 insured, is located; or

27 (2) the title insurance policy is based on a certified

1 abstract of title prepared by a licensed abstract plant covering
2 the particular real property from the sovereignty of the soil to the
3 date of the transaction. (V.T.I.C. Art. 9.56, Sec. 7(c).)

4 [Sections 2552.159-2552.200 reserved for expansion]

5 SUBCHAPTER E. POWERS AND DUTIES OF ATTORNEY'S

6 TITLE INSURANCE COMPANIES

7 Sec. 2552.201. ACTING AS TITLE ATTORNEY. An attorney's
8 title insurance company may not permit an attorney to act as its
9 title attorney in this state, including by writing, signing, or
10 delivering title insurance policies, unless the attorney holds a
11 license issued under Subchapter C and maintains a surety bond or
12 deposit as required by Section 2552.154. (V.T.I.C. Art. 9.56,
13 Secs. 5 (part), 6(b) (part).)

14 Sec. 2552.202. LIST OF TITLE ATTORNEYS. (a) An attorney's
15 title insurance company shall certify to the department the name
16 and address of each title attorney appointed by the attorney's
17 title insurance company.

18 (b) The certification required by this section must:

19 (1) be on a form provided by the department; and

20 (2) be made on or before June 1 of each year unless a
21 system of staggered renewal is adopted under Section 4003.002.
22 (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

23 Sec. 2552.203. RENEWAL. An attorney's title insurance
24 company shall apply for license renewal and pay a fee prescribed by
25 the department in an amount not to exceed \$50 for each title
26 attorney listed under Section 2552.202. (V.T.I.C. Art. 9.56, Sec.
27 6(b) (part).)

1 Sec. 2552.204. NOTICE OF TERMINATION. An attorney's title
2 insurance company that terminates the appointment of a title
3 attorney shall:

4 (1) immediately notify the department in writing of
5 the termination and request cancellation of the title attorney's
6 license; and

7 (2) notify the title attorney of the action by the
8 attorney's title insurance company. (V.T.I.C. Art. 9.56, Sec. 6(b)
9 (part).)

10 [Sections 2552.205-2552.250 reserved for expansion]

11 SUBCHAPTER F. AUDIT AND EXAMINATION REQUIREMENTS

12 RELATING TO TRUST FUND ACCOUNTS

13 Sec. 2552.251. ANNUAL AUDIT. (a) A title attorney shall
14 have an annual audit made of trust fund accounts. The title
15 attorney shall pay for the audit.

16 (b) The audit must be performed by an independent certified
17 public accountant or licensed public accountant, or a firm composed
18 of either, recommended by the title attorney and approved by the
19 attorney's title insurance company represented by the title
20 attorney.

21 (c) The audit must include disclosure of payments made for
22 title evidence under a contract under Section 2552.153 and to whom
23 the payments were made.

24 (d) Not later than the 90th day after January 1 of each year,
25 the title attorney shall send by certified mail, postage prepaid,
26 to the department one copy of the audit report with a transmittal
27 letter. The title attorney shall also send a copy of the audit

1 report and transmittal letter to the attorney's title insurance
2 company represented by the title attorney. (V.T.I.C. Art. 9.56,
3 Secs. 7(d), 10 (part).)

4 Sec. 2552.252. ANALYSIS OF ANNUAL AUDIT. (a) An attorney's
5 title insurance company shall examine and analyze the annual audit
6 report received from each of its title attorneys under Section
7 2552.251.

8 (b) Not later than three months after the date the audit
9 report is received, the attorney's title insurance company shall
10 file with the department, on a form prescribed by the department, a
11 report of the findings and results of the examination and analysis
12 of the audit report.

13 (c) If an attorney's title insurance company fails to
14 receive an audit report from a title attorney within the time
15 required by Section 2552.251, the attorney's title insurance
16 company shall promptly report that fact to the department.

17 (d) After the report of the examination and analysis is
18 filed with the department by an attorney's title insurance company,
19 the department may classify the report as confidential and
20 privileged. (V.T.I.C. Art. 9.56, Sec. 10 (part).)

21 Sec. 2552.253. EXAMINATION OF TRUST FUND ACCOUNTS;
22 TRANSACTION REPORTS. (a) An attorney's title insurance company,
23 through its examiners or auditors or through independent certified
24 public accountants commissioned by the attorney's title insurance
25 company, may examine at any time the trust fund accounts and records
26 relating to the accounts of any of its title attorneys.

27 (b) The attorney's title insurance company shall pay for the

1 examination of the accounts and records.

2 (c) An attorney's title insurance company may require from
3 any of its title attorneys special reports regarding any of their
4 transactions. (V.T.I.C. Art. 9.56, Sec. 11.)

5 Sec. 2552.254. ENFORCEMENT; HEARING. (a) After notice and
6 hearing, the department may revoke the license of a title attorney
7 who:

8 (1) fails to furnish an annual audit report within the
9 time required by Section 2552.251; or

10 (2) furnishes an audit report that reveals any
11 irregularity, including a shortage, or any practice not in keeping
12 with sound, honest business practices.

13 (b) The notice must be provided to the title attorney and
14 the attorney's title insurance company represented by the title
15 attorney.

16 (c) At a hearing under this section, the title attorney and
17 the attorney's title insurance company may offer evidence
18 explaining or excusing a failure or irregularity. (V.T.I.C. Art.
19 9.56, Sec. 10 (part).)

20 [Sections 2552.255-2552.300 reserved for expansion]

21 SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

22 Sec. 2552.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
23 ACTION. The department may deny an application for a title
24 attorney's license or discipline a title attorney under Sections
25 4005.102, 4005.103, and 4005.104 if the department determines that
26 the applicant or license holder:

27 (1) has wilfully violated this title;

1 (2) has intentionally made a material misstatement in
2 the license application;

3 (3) has obtained or attempted to obtain the license by
4 fraud or misrepresentation;

5 (4) has misappropriated or converted to the
6 applicant's or license holder's own use or illegally withheld money
7 belonging to an attorney's title insurance company, an insured, or
8 another person;

9 (5) has been guilty of fraudulent or dishonest
10 practices;

11 (6) has materially misrepresented the terms and
12 conditions of a title insurance policy or contract;

13 (7) has failed to maintain:

14 (A) a separate and distinct accounting of escrow
15 funds; and

16 (B) an escrow bank account or accounts separate
17 and apart from all other accounts;

18 (8) is no longer a member of the State Bar of Texas; or

19 (9) is no longer actively engaged in the practice of
20 law. (V.T.I.C. Art. 9.56, Sec. 8(b).)

21 Sec. 2552.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL,
22 OR REVOCATION. (a) An applicant whose license application has been
23 denied or refused or a license holder whose license has been revoked
24 under this subchapter may not file another application for a title
25 attorney's license before the first anniversary of:

26 (1) the effective date of the denial, refusal, or
27 revocation; or

1 (2) the date of a final court order affirming the
2 denial, refusal, or revocation if judicial review is sought.

3 (b) A license application filed after the time required by
4 this section may be denied by the department unless the applicant
5 shows good cause why the denial, refusal, or revocation should not
6 be a bar to the issuance of a license. (V.T.I.C. Art. 9.56, Sec.
7 8(d).)

8 CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

9 Sec. 2553.001. AUTHORITY TO ENGAGE IN BUSINESS OF TITLE

10 INSURANCE

11 Sec. 2553.002. CAPITAL AND SURPLUS REQUIREMENTS

12 Sec. 2553.003. TAXES AND FEES

13 CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

14 Sec. 2553.001. AUTHORITY TO ENGAGE IN BUSINESS OF TITLE
15 INSURANCE. (a) A corporation organized under the laws of another
16 state may engage in the business of title insurance in this state on
17 exactly the same basis and is subject to the same rules, prices, and
18 supervision as provided for a corporation that is organized under
19 the laws of this state and engaged in the business of title
20 insurance under this title.

21 (b) To engage in the business of title insurance in this
22 state, a foreign corporation must file with the department:

23 (1) an application for a permit or certificate of
24 authority; and

25 (2) a financial statement demonstrating the condition
26 of the corporation.

27 (c) The department shall prescribe the form of the

1 application and financial statement. (V.T.I.C. Arts. 9.10, 9.24.)

2 Sec. 2553.002. CAPITAL AND SURPLUS REQUIREMENTS. (a) A
3 foreign corporation may not engage in the business of title
4 insurance in this state unless the corporation has unimpaired
5 capital in an amount of at least \$1 million and a surplus in an
6 amount of at least \$1 million.

7 (b) The foreign corporation must demonstrate the required
8 capital and surplus from its financial statement and any other
9 examination the department may want to conduct. (V.T.I.C. Art.
10 9.25.)

11 Sec. 2553.003. TAXES AND FEES. (a) A corporation organized
12 and incorporated under the laws of another state, territory, or
13 country for the purpose of engaging in the business of title
14 insurance shall pay the same filing fees and occupation tax as a
15 foreign casualty company is required to pay to obtain a permit to
16 engage in the business of insurance in this state.

17 (b) A foreign title insurance company described by
18 Subsection (a) is not required to pay a franchise tax. (V.T.I.C.
19 Art. 9.31.)

20 [Chapters 2554-2600 reserved for expansion]

21 SUBTITLE C. FINANCIAL SOLVENCY

22 CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION,
23 REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES
24 AND AGENTS

25 Sec. 2601.001. SUPERVISION, LIQUIDATION, REHABILITATION,
26 REORGANIZATION, OR CONSERVATION OF TITLE
27 INSURANCE COMPANIES AND AGENTS

CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION,
REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES
AND AGENTS

Sec. 2601.001. SUPERVISION, LIQUIDATION, REHABILITATION,
REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND
AGENTS. Each title insurance agent and title insurance company is
subject to Articles 21.28 and 21.28-A. (V.T.I.C. Art. 9.29.)

CHAPTER 2602. TEXAS TITLE INSURANCE
GUARANTY ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2602.001. SHORT TITLE

Sec. 2602.002. PURPOSES AND FINDINGS

Sec. 2602.003. DEFINITIONS

Sec. 2602.004. DESCRIPTION OF CONTROL

Sec. 2602.005. APPLICABILITY; CONFLICT WITH OTHER LAWS

Sec. 2602.006. CONSTRUCTION

Sec. 2602.007. PROHIBITED USE OF PROTECTION PROVIDED BY

CHAPTER

Sec. 2602.008. IMMUNITY

Sec. 2602.009. ASSOCIATION AND TITLE INSURANCE COMPANIES AS

INTERESTED PARTIES

Sec. 2602.010. RULES

Sec. 2602.011. INFORMATION PROVIDED BY AND TO

COMMISSIONER

Sec. 2602.012. APPEALS

[Sections 2602.013-2602.050 reserved for expansion]

SUBCHAPTER B. GOVERNANCE OF TEXAS TITLE INSURANCE

GUARANTY ASSOCIATION

Sec. 2602.051. ASSOCIATION AS LEGAL ENTITY; SUPERVISION;
MEMBERSHIP

Sec. 2602.052. BOARD OF DIRECTORS

Sec. 2602.053. ELIGIBILITY TO SERVE AS PUBLIC
REPRESENTATIVE

Sec. 2602.054. TERM; VACANCY

Sec. 2602.055. COMPENSATION OF BOARD MEMBERS

Sec. 2602.056. FINANCIAL STATEMENT OF BOARD MEMBER

Sec. 2602.057. RIGHTS OF TITLE INSURANCE COMPANY WITH
REPRESENTATIVE ON BOARD

[Sections 2602.058-2602.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

Sec. 2602.101. GENERAL POWERS AND DUTIES

Sec. 2602.102. PLAN OF OPERATION

Sec. 2602.103. EMPLOYEES AND EXPERTS

Sec. 2602.104. ASSOCIATION RECORDS

Sec. 2602.105. MEETING BY CONFERENCE CALL

Sec. 2602.106. ACCOUNTS

Sec. 2602.107. ADMINISTRATIVE EXPENSES

Sec. 2602.108. DEPOSIT OF FEES AND ASSESSMENTS

Sec. 2602.109. USE OF EXCESS MONEY IN ACCOUNTS

Sec. 2602.110. EXPENSES OF RECEIVERSHIP OR
CONSERVATORSHIP

Sec. 2602.111. DELEGATION OF POWERS AND DUTIES

Sec. 2602.112. EXEMPTION FROM TAXATION

Sec. 2602.113. DETECTION AND PREVENTION OF IMPAIRMENT

1 Sec. 2602.114. MEETING OF BOARD ON IMPAIRED TITLE INSURANCE

2 COMPANY OR AGENT

3 Sec. 2602.115. ASSOCIATION AND BOARD ADVICE AND

4 ASSISTANCE

5 Sec. 2602.116. BOARD ACCESS TO RECORDS

6 Sec. 2602.117. BOARD REPORT AT CONCLUSION OF IMPAIRMENT

7 [Sections 2602.118-2602.150 reserved for expansion]

8 SUBCHAPTER D. POLICY GUARANTY FEES

9 Sec. 2602.151. PAYMENT OF FEE

10 Sec. 2602.152. AMOUNT OF FEE

11 Sec. 2602.153. USE OF FEE

12 Sec. 2602.154. ENFORCEMENT OF FEE

13 [Sections 2602.155-2602.200 reserved for expansion]

14 SUBCHAPTER E. ASSESSMENTS

15 Sec. 2602.201. MAKING OF ASSESSMENT

16 Sec. 2602.202. AMOUNT OF ASSESSMENT; PRORATION OF

17 PAYMENT

18 Sec. 2602.203. NOTICE AND PAYMENT

19 Sec. 2602.204. EXEMPTION FOR IMPAIRED TITLE INSURANCE

20 COMPANY

21 Sec. 2602.205. DEFERMENT

22 Sec. 2602.206. PARTICIPATION RECEIPTS

23 Sec. 2602.207. ACCOUNTING; REPORTS; REFUND

24 Sec. 2602.208. USE OF ASSESSMENTS

25 Sec. 2602.209. FAILURE TO PAY; COLLECTION BY COMMISSIONER

26 Sec. 2602.210. RECOVERY OF ASSESSMENT IN RATES; TAX

27 CREDIT

[Sections 2602.211-2602.250 reserved for expansion]

SUBCHAPTER F. COVERED CLAIMS

Sec. 2602.251. COVERED CLAIMS IN GENERAL

Sec. 2602.252. CLAIM AGAINST TRUST FUNDS OR ESCROW
ACCOUNT

Sec. 2602.253. CLAIM IN CONNECTION WITH FIDELITY OF
AGENT

Sec. 2602.254. CERTAIN CONSERVATOR AND RECEIVER EXPENSES
COVERED

Sec. 2602.255. CLAIMS NOT COVERED

Sec. 2602.256. AMOUNT OF COVERED CLAIM; LIMIT

Sec. 2602.257. EXHAUSTION OF OTHER RIGHTS REQUIRED

Sec. 2602.258. CERTAIN MONEY AUTHORIZED FOR USE IN PAYING
COVERED CLAIM; LIMIT

Sec. 2602.259. STAY OF PROCEEDINGS; CERTAIN DECISIONS NOT
BINDING

Sec. 2602.260. ADMISSIBILITY OF PAYMENT

[Sections 2602.261-2602.300 reserved for expansion]

SUBCHAPTER G. ASSOCIATION POWERS AND DUTIES RELATING TO
COVERED CLAIMS

Sec. 2602.301. GENERAL POWERS AND DUTIES OF ASSOCIATION IN
CONNECTION WITH PAYMENT OF COVERED
CLAIMS

Sec. 2602.302. PAYMENT OF COVERED CLAIMS

Sec. 2602.303. SERVICING FACILITY

Sec. 2602.304. ADVANCE AS LOAN

Sec. 2602.305. ASSOCIATION IN PLACE OF IMPAIRED TITLE

INSURANCE COMPANY OR AGENT

Sec. 2602.306. ASSIGNMENT OF CLAIMANT'S RIGHTS

Sec. 2602.307. SETTLEMENT BY ASSOCIATION BINDING; PRIORITY OF
CLAIM AND EXPENSES

Sec. 2602.308. REPORT TO RECEIVER

[Sections 2602.309-2602.350 reserved for expansion]

SUBCHAPTER H. CONSERVATOR OR RECEIVER POWERS AND DUTIES
RELATING TO COVERED CLAIMS

Sec. 2602.351. DETERMINATION OF CONSERVATOR CONCERNING
REINSURANCE, ASSUMPTION, OR
SUBSTITUTION

Sec. 2602.352. NOTICE OF DETERMINATION CONCERNING ACTUAL
PAYMENT

Sec. 2602.353. FILING OF COVERED CLAIM

Sec. 2602.354. CLAIM BY PERSON WITH CAUSE OF ACTION AGAINST
INSURED

Sec. 2602.355. REPORT TO ASSOCIATION

[Sections 2602.356-2602.400 reserved for expansion]

SUBCHAPTER I. OPERATION OF IMPAIRED TITLE INSURANCE COMPANY
OR AGENT

Sec. 2602.401. ISSUANCE OR RENEWAL OF POLICIES

Sec. 2602.402. DISTRIBUTIONS TO SHAREHOLDERS AND
AFFILIATES

Sec. 2602.403. ASSETS ATTRIBUTABLE TO COVERED POLICIES

CHAPTER 2602. TEXAS TITLE INSURANCE
GUARANTY ASSOCIATION

SUBCHAPTER A. GENERAL PROVISIONS

1 Sec. 2602.001. SHORT TITLE. This chapter may be cited as
2 the Texas Title Insurance Guaranty Act. (V.T.I.C. Art. 9.48, Sec.
3 1.)

4 Sec. 2602.002. PURPOSES AND FINDINGS. (a) This chapter is
5 for:

6 (1) the purposes and findings stated in Section 1,
7 Article 21.28-A; and

8 (2) the protection of holders of covered claims.

9 (b) This chapter and the powers granted and functions
10 authorized by this chapter shall be exercised to accomplish the
11 purposes of this chapter. (V.T.I.C. Art. 9.48, Secs. 2, 21 (part).)

12 Sec. 2602.003. DEFINITIONS. In this chapter:

13 (1) "Affiliate" means a person who, directly or
14 indirectly, through one or more intermediaries, controls, is
15 controlled by, or is under common control with an impaired title
16 insurance company on December 31 of the year preceding the date the
17 company becomes impaired.

18 (2) "Agent" includes:

19 (A) a title insurance agent, as defined by
20 Section 2501.003;

21 (B) a title attorney, as defined by Section
22 2552.002; and

23 (C) a direct operation or a title insurance
24 company's wholly owned subsidiary or affiliate that performs the
25 services usually and customarily performed by a title insurance
26 agent.

27 (3) "Association" means the Texas Title Insurance

1 Guaranty Association.

2 (4) "Board" means the board of directors of the
3 association.

4 (5) "Impaired agent" means an agent that is:

5 (A) placed in:

6 (i) temporary or permanent receivership
7 under a court order based on a finding of insolvency; or

8 (ii) conservatorship after the
9 commissioner determines that the agent is insolvent; and

10 (B) designated by the commissioner as an impaired
11 agent.

12 (6) "Impaired title insurance company" means a title
13 insurance company that is:

14 (A) placed in:

15 (i) temporary or permanent receivership
16 under a court order based on a finding of insolvency; or

17 (ii) conservatorship after the
18 commissioner determines that the company is insolvent; and

19 (B) designated by the commissioner as an impaired
20 title insurance company.

21 (7) "Net direct written premiums" means the gross
22 amount of premiums paid by policyholders for issuance of title
23 insurance policies insuring risks located in this state and to
24 which this chapter applies, without deduction for premiums for
25 reinsurance ceded to other title insurance companies and not
26 including premiums for reinsurance accepted from other authorized
27 title insurance companies.

1 (8) "Payment of covered claims" means:

2 (A) the actual payment of claims; or

3 (B) the use of money of the impaired title
4 insurance company and money derived from assessments or guaranty
5 fees for consummation of contracts of reinsurance or assumption of
6 liabilities or contracts of substitution to provide for liabilities
7 arising from covered claims.

8 (9) "Trust funds or escrow accounts" includes accounts
9 subject to annual audit under Subchapter D, Chapter 2651.

10 (10) "Unauthorized insurer" means a person, firm,
11 association, or corporation that has engaged in activities
12 prohibited by Subchapter C, Chapter 101, while engaging in the
13 business of title insurance. (V.T.I.C. Art. 9.48, Secs. 5(4), (5),
14 (6), (7), (8), (9), (11), (12), (13), (14).)

15 Sec. 2602.004. DESCRIPTION OF CONTROL. (a) For purposes of
16 this chapter, control is the power to direct, or cause the direction
17 of, the management and policies of a person, other than power that
18 results from an official position with or corporate office held by
19 the person. The power may be possessed directly or indirectly by
20 any means, including through the ownership of voting securities or
21 by contract, other than a commercial contract for goods or
22 nonmanagement services.

23 (b) A person is presumed to control another person if the
24 person directly or indirectly owns, controls, holds with the power
25 to vote, or holds proxies representing 10 percent or more of the
26 voting securities of the other person. This presumption may be
27 rebutted by a showing that the person does not in fact control the

1 other person. (V.T.I.C. Art. 9.48, Sec. 5(15).)

2 Sec. 2602.005. APPLICABILITY; CONFLICT WITH OTHER LAWS.

3 (a) This chapter applies to:

4 (1) a title insurance company engaging in business
5 under this title;

6 (2) all title insurance, direct or reinsurance,
7 written by a title insurance company engaging in business under
8 this title; and

9 (3) trust funds or escrow accounts of:

10 (A) title insurance companies engaging in
11 business under this title; or

12 (B) agents authorized to engage in business in
13 this state and engaging in business under and governed by this
14 title.

15 (b) If this chapter conflicts with another law relating to
16 the subject matter of this chapter or its application, other than
17 Article 21.28 or 21.28-A, this chapter controls. If this chapter
18 conflicts with Article 21.28 or 21.28-A, that article controls.
19 (V.T.I.C. Art. 9.48, Secs. 3 (part), 21 (part).)

20 Sec. 2602.006. CONSTRUCTION. (a) This chapter shall be
21 liberally construed to implement the purposes of this chapter
22 described by Section 2602.002, which shall be used to aid and guide
23 interpretation of this chapter.

24 (b) This chapter does not:

25 (1) expand or diminish a right or obligation between
26 or among policyholders, title insurance companies, or agents; or

27 (2) require a person to assign, waive, or relinquish a

1 claim, right, or cause of action arising under Chapter 541 of this
2 code or Subchapter E, Chapter 17, Business & Commerce Code.
3 (V.T.I.C. Art. 9.48, Secs. 3 (part), 4.)

4 Sec. 2602.007. PROHIBITED USE OF PROTECTION PROVIDED BY
5 CHAPTER. (a) A title insurance company or agent may not advertise
6 or refer to this chapter as an inducement to the purchase of title
7 insurance.

8 (b) The use by a person of the protection provided by this
9 chapter in the sale of insurance is unfair competition and an unfair
10 practice under Chapter 541. (V.T.I.C. Art. 9.48, Secs. 16, 19(b).)

11 Sec. 2602.008. IMMUNITY. (a) Liability does not exist and
12 a cause of action does not arise against any of the following
13 persons for a good faith action or omission of the person in
14 exercising the person's powers and performing the person's duties
15 under this chapter:

16 (1) the commissioner or the commissioner's
17 representative;

18 (2) the association or the association's agent or
19 employee;

20 (3) a title insurance company or the company's agent or
21 employee;

22 (4) a board member; and

23 (5) a special deputy receiver or the special deputy
24 receiver's agent or employee.

25 (b) The attorney general shall defend any action to which
26 Subsection (a) applies that is brought against a person listed in
27 that subsection, including an action instituted after the

defendant's service with the association, commissioner, or department has terminated. This subsection does not require the attorney general to defend a person or entity with respect to an issue other than the applicability or effect of the immunity created by Subsection (a). The attorney general is not required to defend a person listed in Subsection (a)(2), (3), (4), or (5) against an action regarding the disposition of a claim filed with the association under this chapter or any issue other than the applicability or effect of the immunity created by Subsection (a). The association may contract with the attorney general under Chapter 771, Government Code, for legal services not covered by this subsection.

(c) A title insurance company that reinsures or assumes the policies of an impaired title insurance company is not liable, and a cause of action does not arise against that company:

(1) for an action or omission by the impaired title insurance company or an officer, director, employee, attorney, or agent of the impaired title insurance company;

(2) by subrogation; or

(3) under any type of indemnity agreement. (V.T.I.C. Art. 9.48, Secs. 10(i) (part), 17.)

Sec. 2602.009. ASSOCIATION AND TITLE INSURANCE COMPANIES AS INTERESTED PARTIES. The association and each title insurance company assessed under this chapter are interested parties under Sections 3(h) and 12(b), Article 21.28. (V.T.I.C. Art. 9.48, Sec. 14(e)(8).)

Sec. 2602.010. RULES. The commissioner shall adopt

1 reasonable rules as necessary to implement and supplement this
2 chapter and its purposes. (V.T.I.C. Art. 9.48, Sec. 18.)

3 Sec. 2602.011. INFORMATION PROVIDED BY AND TO COMMISSIONER.

4 (a) The commissioner shall notify the association of the existence
5 of an impaired title insurance company not later than the third day
6 after the date on which the commissioner gives notice of the
7 designation of impairment. The association is entitled to a copy of
8 any complaint seeking an order of receivership with a finding of
9 insolvency against a title insurance company at the time the
10 complaint is filed with a court.

11 (b) The commissioner shall notify the board when the
12 commissioner receives a report from the commissioner of insurance
13 or other analogous officer of another state that indicates that a
14 title insurance company has been designated impaired in another
15 state. The report to the board must contain all significant details
16 of the action taken or the report received.

17 (c) The commissioner shall report to the board when the
18 commissioner has reasonable cause to believe from a completed or
19 continuing examination of any title insurance company that the
20 company may be an impaired title insurance company. The board may
21 use this information in performing its duties under this chapter.
22 The board shall keep the report and the information contained in the
23 report confidential until it is made public by the commissioner or
24 other lawful authority.

25 (d) On the board's request, the commissioner shall provide
26 the association with a statement of the net direct written premiums
27 of each title insurance company.

1 (e) The commissioner may require that the association
2 notify the insureds of the impaired title insurance company and any
3 other interested party of the designation of impairment and of the
4 person's rights under this chapter. Notification by publication in
5 a newspaper of general circulation is sufficient notice under this
6 section. (V.T.I.C. Art. 9.48, Sec. 15A.)

7 Sec. 2602.012. APPEALS. (a) A title insurance company may
8 appeal to the commissioner an action or ruling of the association
9 relating to an assessment.

10 (b) An action or ruling of the commissioner under this
11 chapter may be appealed as provided by Subchapter D, Chapter 36.

12 (c) A title insurance company appealing an assessment shall
13 pay the assessment. The association may use the money to meet its
14 obligations while the appeal is pending. If the appeal on the
15 assessment is upheld, the association shall return to the company
16 the amount paid in error or excess.

17 (d) Venue in a suit relating to an action or ruling under
18 this chapter is in Travis County. Each party to the action may
19 appeal, and the appeal is at once returnable to the appellate court
20 and has precedence over all cases of a different character pending
21 before the court. The commissioner or association is not required
22 to give an appeal bond in an appeal of a cause of action arising
23 under this chapter. (V.T.I.C. Art. 9.48, Sec. 20.)

24 [Sections 2602.013-2602.050 reserved for expansion]

25 SUBCHAPTER B. GOVERNANCE OF TEXAS TITLE INSURANCE

26 GUARANTY ASSOCIATION

27 Sec. 2602.051. ASSOCIATION AS LEGAL ENTITY; SUPERVISION;

1 MEMBERSHIP. (a) The Texas Title Insurance Guaranty Association is
2 a nonprofit legal entity.

3 (b) The association is subject to the applicable insurance
4 laws of this state and the immediate supervision of the
5 commissioner.

6 (c) A title insurance company may not engage in the business
7 of title insurance in this state unless the company is a member of
8 the association. (V.T.I.C. Art. 9.48, Sec. 14(a) (part).)

9 Sec. 2602.052. BOARD OF DIRECTORS. (a) The association's
10 powers are exercised through a board of directors consisting of
11 nine individuals appointed by the commissioner.

12 (b) Three board members must be officers or employees of
13 title insurance companies. Two board members must be officers or
14 employees of agents. Four board members must be public
15 representatives.

16 (c) Board members other than public representatives shall
17 be chosen to give fair representation to all title insurance
18 companies and agents, considering the following categories:

- 19 (1) premium income;
20 (2) geographical location; and
21 (3) segments of the industry represented in this
22 state. (V.T.I.C. Art. 9.48, Secs. 14(a) (part), (b)(1) (part).)

23 Sec. 2602.053. ELIGIBILITY TO SERVE AS PUBLIC
24 REPRESENTATIVE. (a) In this section, "immediate family" includes
25 parents, a spouse, children, brothers, and sisters residing in the
26 same household.

27 (b) To be eligible to serve as a public representative on

1 the board, an individual must have resided in this state during the
2 five years preceding appointment and may not be:

3 (1) licensed by or subject to the regulation of the
4 department;

5 (2) financially involved in an organization subject to
6 the regulation of the department other than by ownership of an
7 insurance policy or contract;

8 (3) a member of the immediate family of an individual
9 who is financially involved in an organization subject to the
10 regulation of the department;

11 (4) engaged in or employed by an entity having a
12 contract with an organization subject to the regulation of the
13 department;

14 (5) employed by, on the board of directors of, or a
15 holder of an elective office by or under the authority of a unit of
16 federal, state, or local government or an organization that
17 receives a significant part of its funding from a unit of federal,
18 state, or local government;

19 (6) employed by or associated with an organization
20 formed to represent license holders of the department or
21 organizations or individuals subject to the regulation of the
22 department; or

23 (7) required to register as a lobbyist under Chapter
24 305, Government Code, because of activities on behalf of an
25 organization representing the regulated industry. (V.T.I.C. Art.
26 9.48, Sec. 14(b)(1) (part).)

27 Sec. 2602.054. TERM; VACANCY. (a) Board members serve

1 staggered six-year terms, with the terms of three members expiring
2 each odd-numbered year. A member may serve more than one term.

3 (b) A member shall serve until a successor is appointed.

4 (c) If a member other than a public representative ceases to
5 be an officer or employee of a title insurance company or agent, the
6 member's office becomes vacant.

7 (d) The commissioner shall appoint an individual to fill a
8 vacancy on the board for the unexpired term. (V.T.I.C. Art. 9.48,
9 Sec. 14(b)(1) (part).)

10 Sec. 2602.055. COMPENSATION OF BOARD MEMBERS. A board
11 member may not receive compensation for the member's services but
12 is entitled to reimbursement for actual expenses incurred in
13 performing the member's duties. (V.T.I.C. Art. 9.48, Sec.
14 14(b)(2).)

15 Sec. 2602.056. FINANCIAL STATEMENT OF BOARD MEMBER. Each
16 board member shall file with the Texas Ethics Commission a
17 financial statement as provided by Subchapter B, Chapter 572,
18 Government Code. (V.T.I.C. Art. 9.48, Secs. 14(b)(3), (c) (part).)

19 Sec. 2602.057. RIGHTS OF TITLE INSURANCE COMPANY WITH
20 REPRESENTATIVE ON BOARD. (a) A title insurance company is not
21 prohibited, because the company has an officer, director, or
22 employee serving as a board member, from negotiating for or
23 entering into a contract of reinsurance or assumption of liability
24 or a contract of substitution to provide for liabilities for
25 covered claims with the receiver or conservator of an impaired
26 title insurance company or agent.

27 (b) A conflict of interest does not arise from entering into

1 a contract described by this section. (V.T.I.C. Art. 9.48, Sec.
2 14(e)(7).)

3 [Sections 2602.058-2602.100 reserved for expansion]

4 SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

5 Sec. 2602.101. GENERAL POWERS AND DUTIES. (a) In addition
6 to the other powers and duties provided by this chapter, the
7 association may:

8 (1) borrow money as necessary to implement this
9 chapter according to the plan of operation;

10 (2) lend money to an impaired title insurance company;

11 (3) sue and be sued, including taking any legal action
12 necessary or proper to recover an unpaid assessment;

13 (4) enter into contracts as necessary or proper to
14 implement this chapter;

15 (5) ensure payment of the policy obligations of an
16 impaired title insurance company;

17 (6) negotiate and contract with a rehabilitator,
18 conservator, receiver, or ancillary receiver to exercise the powers
19 and perform the duties of the association;

20 (7) guarantee, assume, or reinsure, or cause to be
21 guaranteed, assumed, or reinsured, a policy or contract of an
22 impaired title insurance company;

23 (8) take legal action necessary to avoid the payment
24 of improper claims or to settle claims or potential claims against
25 an impaired title insurance company or the association; and

26 (9) perform any other acts as necessary or proper to
27 implement this chapter.

1 (b) The association has standing to appear before a court in
2 this state with jurisdiction over an impaired title insurance
3 company or agent concerning which the association is or may become
4 obligated under this chapter. (V.T.I.C. Art. 9.48, Sec. 14(c)
5 (part).)

6 Sec. 2602.102. PLAN OF OPERATION. (a) The association
7 shall perform its functions under a plan of operation. The plan of
8 operation must contain provisions necessary or proper for the
9 execution of the association's powers and duties. The plan of
10 operation must, in addition to the other requirements of this
11 chapter:

12 (1) establish:

13 (A) procedures for handling the assets of the
14 association;

15 (B) the amount and method of reimbursing board
16 members;

17 (C) regular places and times for board meetings;

18 (D) procedures for maintaining records of all
19 financial transactions of the association, its agents, and the
20 board; and

21 (E) procedures for determining the amount of
22 guaranty fees, for collecting those fees, and for assessments; and

23 (2) contain additional provisions necessary or proper
24 for the execution of the association's powers and duties.

25 (b) The association shall submit to the commissioner any
26 amendment to the plan of operation necessary or suitable to ensure
27 the fair, reasonable, and equitable administration of the

1 association. The amendment takes effect on the commissioner's
2 written approval.

3 (c) If the association does not submit a suitable amendment
4 to the plan of operation, the commissioner after notice and hearing
5 may adopt reasonable rules as necessary or advisable to implement
6 this chapter. A rule continues in effect until modified by the
7 commissioner or superseded by an amendment submitted by the
8 association and approved by the commissioner.

9 (d) Each title insurance company shall comply with the plan
10 of operation. (V.T.I.C. Art. 9.48, Secs. 14(a) (part), (d)(1), (2)
11 (part), (3), (4).)

12 Sec. 2602.103. EMPLOYEES AND EXPERTS. (a) The association
13 may employ or retain persons to perform the functions necessary or
14 proper under this chapter, including persons necessary to handle
15 the association's financial transactions.

16 (b) On the commissioner's request, the association shall
17 retain one or more persons to:

18 (1) audit and review agent escrow and trust accounts,
19 financial condition, and compliance with applicable statutes and
20 rules; and

21 (2) report to the commissioner on the accounts,
22 condition, and compliance.

23 (c) A person retained under Subsection (b) acts solely under
24 the direction of and as assigned by the commissioner.

25 (d) From the guaranty fee account, the association shall
26 compensate a person retained under Subsection (b) and reimburse the
27 person for the person's reasonable and necessary expenses.

1 (V.T.I.C. Art. 9.48, Sec. 14(c) (part).)

2 Sec. 2602.104. ASSOCIATION RECORDS. (a) The association
3 shall maintain a record of each negotiation or meeting in which the
4 association or the association's representative discusses the
5 association's activities in exercising its powers and performing
6 its duties under this chapter.

7 (b) A record under Subsection (a) may be made public only
8 on:

9 (1) termination of a liquidation, rehabilitation, or
10 conservation proceeding involving the impaired or insolvent title
11 insurance company;

12 (2) termination of the impairment or insolvency of the
13 title insurance company; or

14 (3) order of a court.

15 (c) This section does not limit the association's duty to
16 report on its activities under this chapter. (V.T.I.C. Art. 9.48,
17 Sec. 23(a).)

18 Sec. 2602.105. MEETING BY CONFERENCE CALL. Notwithstanding
19 Chapter 551, Government Code, the board may hold an open meeting by
20 telephone conference call if immediate action is required and
21 convening of a quorum of the board at a single location is not
22 reasonable or practical. The meeting is subject to the notice
23 requirements that apply to other meetings. The notice of the
24 meeting must specify as the location of the meeting the location at
25 which meetings of the board are usually held, and each part of the
26 meeting that is required to be open to the public must be audible to
27 the public at that location and must be tape-recorded. The tape

1 recording shall be made available to the public for 30 days after
2 the meeting date. (V.T.I.C. Art. 9.48, Sec. 14(g).)

3 Sec. 2602.106. ACCOUNTS. For purposes of administration
4 and assessment, the board shall establish:

- 5 (1) an administrative account;
- 6 (2) a title account; and
- 7 (3) a guaranty fee account. (V.T.I.C. Art. 9.48, Sec.
8 14(a) (part).)

9 Sec. 2602.107. ADMINISTRATIVE EXPENSES. (a) The
10 association may use money in the administrative account to pay
11 administrative costs and other general expenses of the association.

12 (b) The association may transfer income from investment of
13 the association's money to the administrative account.

14 (c) The association shall assess title insurance companies
15 as provided by Subchapter E for any additional money needed for the
16 administrative account. (V.T.I.C. Art. 9.48, Sec. 7(e).)

17 Sec. 2602.108. DEPOSIT OF FEES AND ASSESSMENTS. The
18 association may deposit fees and assessments it collects into the
19 Texas Treasury Safekeeping Trust Company in accordance with
20 procedures established by the comptroller. The comptroller shall
21 account to the association for the deposited money separately from
22 all other money. (V.T.I.C. Art. 9.48, Sec. 6A.)

23 Sec. 2602.109. USE OF EXCESS MONEY IN ACCOUNTS. (a) If the
24 association determines that money in the title account exceeds the
25 amount reasonably necessary for efficient future operation under
26 this chapter, the association shall return the excess money pro
27 rata to the holders of participation receipts on which an

1 outstanding balance exists after deducting any credits against
2 premium taxes taken under Section 2602.210. The amount deducted
3 for those credits shall be deposited with the comptroller for
4 credit to the general revenue fund. The association shall transfer
5 to the guaranty fee account any excess money remaining in the title
6 account after the distribution.

7 (b) If the association determines that money in the
8 administrative account exceeds the amount reasonably necessary for
9 efficient future operation under this chapter, the association
10 shall transfer the excess money to the guaranty fee account.
11 (V.T.I.C. Art. 9.48, Secs. 9(b), (c).)

12 Sec. 2602.110. EXPENSES OF RECEIVERSHIP OR
13 CONSERVATORSHIP. The association may advance money necessary to
14 pay the expenses of administering the receivership or
15 conservatorship estate of an impaired title insurance company or
16 agent, on terms the association negotiates, if the company's or
17 agent's assets are insufficient to pay those expenses. (V.T.I.C.
18 Art. 9.48, Sec. 5(2)C (part).)

19 Sec. 2602.111. DELEGATION OF POWERS AND DUTIES. (a) The
20 plan of operation may provide that, on approval of the board and the
21 commissioner, a power or duty of the association may be delegated to
22 a corporation or other organization that:

23 (1) performs or will perform in two or more states
24 functions similar to those of the association or its equivalent;
25 and

26 (2) provides protection not substantially less
27 favorable and effective than that provided by this chapter.

1 (b) A power or duty under Section 2602.101(a)(1) or (4),
2 2602.107, 2602.201, 2602.202, 2602.203, or 2602.205 may not be
3 delegated under this section.

4 (c) The corporation or other organization shall be:

5 (1) reimbursed as a servicing facility would be
6 reimbursed; and

7 (2) paid for its performance of any other functions of
8 the association. (V.T.I.C. Art. 9.48, Sec. 14(f).)

9 Sec. 2602.112. EXEMPTION FROM TAXATION. The association is
10 exempt from payment of all fees and all taxes levied by this state
11 or a subdivision of this state, except taxes levied on real or
12 personal property. (V.T.I.C. Art. 9.48, Sec. 20A.)

13 Sec. 2602.113. DETECTION AND PREVENTION OF IMPAIRMENT. (a)
14 The board may make recommendations to the commissioner for
15 detecting and preventing title insurance company or agent
16 impairments. The board shall advise and counsel with the
17 commissioner on matters relating to the solvency of title insurance
18 companies and agents.

19 (b) The board may report and make recommendations to the
20 commissioner relating to any matter germane to the solvency,
21 liquidation, rehabilitation, or conservation of a title insurance
22 company or agent. A report or recommendation under this subsection
23 is not a public document until a title insurance company is
24 designated impaired.

25 (c) The board shall notify the commissioner of any
26 information indicating that a title insurance company or agent may
27 be unable or potentially unable to fulfill its contractual

1 obligations and shall request a meeting with the commissioner. The
2 board may request appropriate investigation and action by the
3 commissioner. The commissioner may investigate and act as the
4 commissioner considers appropriate. (V.T.I.C. Art. 9.48, Secs.
5 14(e)(2), (3) (part), (4), (5).)

6 Sec. 2602.114. MEETING OF BOARD ON IMPAIRED TITLE INSURANCE
7 COMPANY OR AGENT. (a) The commissioner:

8 (1) shall call a meeting of the board when the
9 commissioner determines that a title insurance company or agent is
10 insolvent or impaired; and

11 (2) may call a meeting of the board when the
12 commissioner determines that a title insurance company or agent is
13 in danger of becoming insolvent or impaired.

14 (b) The meeting is not open to the public. Only board
15 members, the commissioner, and persons the commissioner authorizes
16 may attend the meeting.

17 (c) The commissioner may require an officer, director, or
18 employee of the title insurance company or agent to appear before
19 the board for conference or to give testimony.

20 (d) At the meeting the commissioner may disclose to the
21 board information that the commissioner possesses and may disclose
22 department records, including an examination report or a
23 preliminary report from an examiner that relates to the title
24 insurance company or agent.

25 (e) A board member may not disclose information received in
26 the meeting unless authorized by the commissioner or required as
27 witness in court. A board member and the meeting are subject to the

1 confidentiality standard imposed on an examiner under Article 1.18,
2 except that a bond is not required of a board member. (V.T.I.C.
3 Art. 9.48, Sec. 14(e)(3) (part).)

4 Sec. 2602.115. ASSOCIATION AND BOARD ADVICE AND ASSISTANCE.

5 (a) On the commissioner's request, the board shall attend hearings
6 before the commissioner and meet with and advise the commissioner
7 or the receiver or the conservator appointed by the commissioner on
8 matters relating to:

9 (1) the affairs of an impaired title insurance company
10 or agent;

11 (2) action that the commissioner, receiver, or
12 conservator may take to best protect the interest of holders of
13 covered claims against the company or agent; and

14 (3) the marshalling of assets.

15 (b) On the commissioner's request, the association may
16 assist and advise the commissioner concerning rehabilitation,
17 payment of claims, continuation of coverage, or the performance of
18 other contractual obligations of an impaired title insurance
19 company or agent. (V.T.I.C. Art. 9.48, Secs. 14(c) (part), (e)(3)
20 (part).)

21 Sec. 2602.116. BOARD ACCESS TO RECORDS. The receiver or
22 statutory successor of an impaired title insurance company shall
23 give the board or its representative:

24 (1) access to the company's records as necessary for
25 the board to perform its functions under this chapter relating to
26 covered claims; and

27 (2) copies of those records on the board's request and

1 at the board's expense. (V.T.I.C. Art. 9.48, Sec. 20B (part).)

2 Sec. 2602.117. BOARD REPORT AT CONCLUSION OF IMPAIRMENT.
3 At the conclusion of a title insurance company or agent impairment
4 in which the association exercised its powers or performed its
5 duties under this chapter, the board shall prepare, from
6 information available to the association, and submit to the
7 commissioner a report on the history and causes of the impairment.
8 (V.T.I.C. Art. 9.48, Sec. 14(e)(6).)

9 [Sections 2602.118-2602.150 reserved for expansion]

10 SUBCHAPTER D. POLICY GUARANTY FEES

11 Sec. 2602.151. PAYMENT OF FEE. (a) An agent or, if there is
12 no agent, the title insurance company shall pay the association a
13 quarterly guaranty fee for each owner or mortgagee title insurance
14 policy that the agent or company is required to report on its
15 statistical report to the department.

16 (b) The fee is due:

- 17 (1) May 1, for the quarter ending March 31;
18 (2) August 1, for the quarter ending June 30;
19 (3) November 1, for the quarter ending September 30;

20 and

- 21 (4) February 1, for the quarter ending December 31.

22 (c) The association shall deposit the fee in the guaranty
23 fee account.

24 (d) Except as provided by Section 2602.109, money in the
25 guaranty fee account shall be derived only from guaranty fees as
26 provided by this subchapter. (V.T.I.C. Art. 9.48, Secs. 6(a)
27 (part), (b), 7(c) (part).)

1 Sec. 2602.152. AMOUNT OF FEE. Annually or more frequently,
2 the board shall determine the amount of the guaranty fee, not to
3 exceed \$5, considering the amount of money to be maintained in the
4 guaranty fee account that is reasonably necessary for efficient
5 future operation under this chapter. (V.T.I.C. Art. 9.48, Sec.
6 6(a) (part).)

7 Sec. 2602.153. USE OF FEE. (a) The association shall
8 collect, receive, retain, and disburse the guaranty fees only as
9 specifically provided by this chapter.

10 (b) The following covered claims shall be paid from guaranty
11 fees only and may not be paid from assessments:

12 (1) claims against trust funds or an escrow account of
13 an impaired agent under Section 2602.252; and

14 (2) conservator and receiver expenses under Section
15 2602.254.

16 (c) Administrative expenses with respect to the estate of an
17 impaired agent under Section 2602.110 may be paid only from the
18 guaranty fee account.

19 (d) Guaranty fees may be used only for payment of:

20 (1) covered claims described by Subsection (b) or (c);
21 and

22 (2) audit and review expenses under Section
23 2602.103(b). (V.T.I.C. Art. 9.48, Secs. 5(2)A (part), C (part), D
24 (part), 6(c), 14(c) (part).)

25 Sec. 2602.154. ENFORCEMENT OF FEE. (a) After notice and
26 opportunity for hearing, the commissioner may suspend or revoke the
27 certificate of authority or license to engage in business in this

1 state of a title insurance company or agent that does not comply
2 with this subchapter.

3 (b) The commissioner shall adopt rules that implement the
4 program created under this subchapter. (V.T.I.C. Art. 9.48, Secs.
5 6(d), (e).)

6 [Sections 2602.155-2602.200 reserved for expansion]

7 SUBCHAPTER E. ASSESSMENTS

8 Sec. 2602.201. MAKING OF ASSESSMENT. (a) If the
9 commissioner determines that a title insurance company or agent has
10 become impaired, the association shall promptly estimate the amount
11 of additional money needed to supplement the assets of the impaired
12 title insurance company or agent to pay all covered claims and
13 administrative expenses.

14 (b) The association shall assess title insurance companies
15 in writing an amount as determined under Section 2602.202. A title
16 insurance company does not incur real or contingent liability under
17 this chapter until the association actually makes the written
18 assessment. (V.T.I.C. Art. 9.48, Secs. 7(a), (b) (part), (f).)

19 Sec. 2602.202. AMOUNT OF ASSESSMENT; PRORATION OF PAYMENT.

20 (a) The association shall assess title insurance companies the
21 amount necessary to pay:

22 (1) the association's obligations under this chapter
23 and the expenses of handling covered claims subsequent to an
24 impairment; and

25 (2) other expenses authorized by this chapter.

26 (b) The assessment of each title insurance company must be
27 in the proportion that the net direct written premiums of that

1 company for the calendar year preceding the assessment bear to the
2 net direct written premiums of all title insurance companies for
3 that year.

4 (c) The total assessment of a title insurance company in a
5 year may not exceed an amount equal to two percent of the company's
6 net direct written premiums for the calendar year preceding the
7 assessment. If the maximum assessment and the association's other
8 assets are insufficient in any one year to make all necessary
9 payments, the money available shall be prorated and the unpaid
10 portion shall be paid as soon as money becomes available. (V.T.I.C.
11 Art. 9.48, Sec. 7(b) (part).)

12 Sec. 2602.203. NOTICE AND PAYMENT. (a) Not later than the
13 30th day before the date an assessment is due, the association shall
14 notify the title insurance company.

15 (b) Not later than the 30th day after the date an assessment
16 is made, the title insurance company shall pay the association the
17 amount of the assessment. (V.T.I.C. Art. 9.48, Secs. 7(b) (part),
18 (d) (part).)

19 Sec. 2602.204. EXEMPTION FOR IMPAIRED TITLE INSURANCE
20 COMPANY. A title insurance company is exempt from assessment
21 during the period beginning on the date the commissioner designates
22 the company as an impaired title insurance company and ending on the
23 date the commissioner determines that the company is no longer an
24 impaired title insurance company. (V.T.I.C. Art. 9.48, Sec. 7(g).)

25 Sec. 2602.205. DEFERMENT. (a) The association may defer in
26 whole or in part an assessment of a title insurance company that
27 would cause the company's financial statement to show amounts of

1 capital or surplus less than the minimum amount required for a
2 certificate of authority in any jurisdiction in which the company
3 is authorized to engage in the business of insurance.

4 (b) The title insurance company shall pay the deferred
5 assessment when payment will not reduce capital or surplus below
6 required minimums. The payment shall be refunded to or credited
7 against future assessments of any title insurance company receiving
8 a larger assessment because of the deferment, as elected by that
9 company.

10 (c) During a period of deferment, the title insurance
11 company may not pay a dividend to shareholders or policyholders.
12 (V.T.I.C. Art. 9.48, Sec. 7(c) (part).)

13 Sec. 2602.206. PARTICIPATION RECEIPTS. (a) On receipt
14 from a title insurance company of payment of an assessment or
15 partial assessment, the association shall provide the company with
16 a participation receipt. A participation receipt creates liability
17 against the impaired title insurance company.

18 (b) The holder of the receipt is a general creditor of the
19 impaired title insurance company, except that if the amount of
20 assessments the association receives exceeds the amount paid for
21 covered claims, the holders of participation receipts have
22 preference over other general creditors to, and are entitled to
23 share pro rata in, the excess. (V.T.I.C. Art. 9.48, Sec. 9(a)
24 (part).)

25 Sec. 2602.207. ACCOUNTING; REPORTS; REFUND. (a) The
26 association shall adopt accounting procedures to show how money
27 received from assessments or partial assessments is used.

1 (b) The association shall make interim accounting reports
2 as the commissioner requires.

3 (c) The association shall make a final report to the
4 commissioner showing how money received from assessments or partial
5 assessments has been used, including a statement of any final
6 balance of that money. As soon as practicable after completion of
7 the final report, the association shall refund the remaining
8 balance to the holders of participation receipts as required by
9 Section 2602.206(b). (V.T.I.C. Art. 9.48, Sec. 9(a) (part).)

10 Sec. 2602.208. USE OF ASSESSMENTS. (a) Money from
11 assessments is considered to supplement the marshalling of an
12 impaired title insurance company's assets to make payments on the
13 impaired title insurance company's behalf. The association may
14 assess title insurance companies or use money from assessments to
15 pay covered claims before the receiver exhausts the impaired title
16 insurance company's assets.

17 (b) The association may use money from assessments to
18 negotiate and consummate contracts of reinsurance or assumption of
19 liabilities or contracts of substitution to provide for outstanding
20 liabilities of covered claims.

21 (c) Except as provided by Section 2602.109, money from
22 assessments may not be used for the guaranty fee account. (V.T.I.C.
23 Art. 9.48, Secs. 7(c) (part), 7A, 10(i) (part).)

24 Sec. 2602.209. FAILURE TO PAY; COLLECTION BY COMMISSIONER.

25 (a) The association shall promptly report to the commissioner a
26 failure of a title insurance company to pay an assessment when due.

27 (b) On failure of a title insurance company to pay an

1 assessment when due, the commissioner may either:

2 (1) suspend or revoke, after notice and hearing, the
3 company's certificate of authority to engage in business in this
4 state; or

5 (2) assess an administrative penalty as provided by
6 Chapter 84 in an amount not to exceed the greater of five percent of
7 the unpaid assessment each month or \$100 each month.

8 (c) A title insurance company whose certificate of
9 authority is canceled or surrendered is liable for any unpaid
10 assessments made before the date of the cancellation or surrender.

11 (d) The commissioner may collect an assessment on behalf of
12 the association through a suit brought for that purpose. (V.T.I.C.
13 Art. 9.48, Secs. 7(d) (part), 8.)

14 Sec. 2602.210. RECOVERY OF ASSESSMENT IN RATES; TAX CREDIT.

15 (a) A title insurance company is entitled to recover in its rates
16 for the succeeding calendar year amounts paid in assessments not to
17 exceed one percent of the company's net direct written premiums. In
18 promulgating or establishing rates the commissioner shall consider
19 assessments and refunds of assessments and shall adjust the rates
20 to allow for recovery under this subsection.

21 (b) Unless the department determines that all amounts paid
22 as assessments by each title insurance company have been recovered
23 under Subsection (a), for any amount not recovered the title
24 insurance company is entitled to a credit against its premium tax
25 under Chapter 223. The credit may be taken at a rate of 20 percent
26 each year for five successive years following the date of
27 assessment and, if the title insurance company elects, may be taken

over an additional number of years.

(c) An amount of a tax credit allowed by this section that is unclaimed may be shown in the title insurance company's books and records as an admitted asset for all purposes, including an annual statement under Section 862.001. (V.T.I.C. Art. 9.48, Sec. 15.)

[Sections 2602.211-2602.250 reserved for expansion]

SUBCHAPTER F. COVERED CLAIMS

Sec. 2602.251. COVERED CLAIMS IN GENERAL. An unpaid claim is a covered claim if:

(1) the claim is made by an insured under a title insurance policy to which this chapter applies;

(2) the claim arises out of the policy and is within the coverage and applicable limits of the policy;

(3) the title insurance company that issued the policy or assumed the policy under an assumption certificate is an impaired title insurance company; and

(4) the insured real property or a lien on the property is located in this state. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Sec. 2602.252. CLAIM AGAINST TRUST FUNDS OR ESCROW ACCOUNT. An unpaid claim is a covered claim if the claim:

(1) is against trust funds or an escrow account of an impaired title insurance company or agent; and

(2) is unpaid because of a shortage of those funds or in that account. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Sec. 2602.253. CLAIM IN CONNECTION WITH FIDELITY OF AGENT. An unpaid claim is a covered claim if an impaired title insurance company is liable for the claim in connection with the fidelity of

1 the company's agent as authorized by Subchapter A, Chapter 2702.
2 (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

3 Sec. 2602.254. CERTAIN CONSERVATOR AND RECEIVER EXPENSES
4 COVERED. Reasonable and necessary administrative expenses
5 incurred by a conservator appointed by the commissioner or a
6 receiver appointed by a court for an unauthorized insurer operating
7 in this state are covered claims if the commissioner has notified
8 the association or the association has otherwise become aware that:

9 (1) the unauthorized insurer has insufficient liquid
10 assets to pay those expenses; and

11 (2) insufficient money is available from:

12 (A) abandoned money under Section 8, Article
13 21.28; and

14 (B) department appropriations for use in paying
15 those expenses. (V.T.I.C. Art. 9.48, Sec. 5(2)D (part).)

16 Sec. 2602.255. CLAIMS NOT COVERED. The following are not
17 covered claims:

18 (1) an amount due a reinsurer, title insurance
19 company, insurance pool, or underwriting association as a
20 subrogation recovery or otherwise;

21 (2) a supplementary payment obligation incurred
22 before a determination is made under this chapter that a title
23 insurance company or agent is impaired, including:

24 (A) adjustment fees or expenses;

25 (B) attorney's fees or expenses;

26 (C) court costs;

27 (D) interest;

1 (E) enhanced damages, sought as a recovery
2 against the insured, the impaired title insurance company or agent,
3 or the association, that arise under Chapter 541 of this code or
4 Subchapter E, Chapter 17, Business & Commerce Code; and

5 (F) bond premiums;

6 (3) a shortage of trust funds or in an escrow account
7 resulting from the insolvency of a financial institution;

8 (4) exemplary, extracontractual, or bad faith damages
9 awarded against an insured or title insurance company by a court
10 judgment;

11 (5) a claim under Section 2602.252 by a claimant who
12 has a lien against the real property that was the subject of the
13 transaction from which the claim arises, unless the lien is held to
14 be invalid as a matter of law;

15 (6) a claim under Section 2602.251, 2602.252, or
16 2602.253 by a claimant who caused or substantially contributed to
17 the claimant's loss by the claimant's action or omission; and

18 (7) a claim filed with the association after the final
19 date set by the court for the filing of claims against a receiver of
20 an impaired title insurance company or agent. (V.T.I.C. Art. 9.48,
21 Secs. 5(2)B, 10(c).)

22 Sec. 2602.256. AMOUNT OF COVERED CLAIM; LIMIT. (a) A
23 covered claim under Section 2602.251 or 2602.253 may not exceed the
24 lesser of \$250,000 for each claimant or \$250,000 for each policy.

25 (b) A covered claim under Section 2602.252 may not exceed
26 the lesser of \$250,000 for each claimant or the amount of money
27 actually delivered to the impaired title insurance company or agent

1 as trust funds or an escrow account for each claimant in a
2 transaction from which the claim arises, except that the cumulative
3 amount of covered claims arising from a single transaction may not
4 exceed \$250,000. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

5 Sec. 2602.257. EXHAUSTION OF OTHER RIGHTS REQUIRED. (a) A
6 person having a covered claim that is also a claim against a title
7 insurance company under law or under an insurance policy other than
8 a policy of an impaired title insurance company must exhaust the
9 person's rights under law or the policy before asserting the
10 covered claim under this chapter.

11 (b) The amount payable on the covered claim is reduced by
12 the amount of any recovery under law or the policy.

13 (c) Notwithstanding any other provision, to avoid undue
14 hardship to a claimant the association may authorize payment of a
15 covered claim against an impaired agent without regard to the
16 liability of any title insurance company or coverage under any
17 insurance policy, subject to the approval of the receivership court
18 or commissioner, as applicable. On payment, the association is in
19 all respects subrogated to the rights and claims of the claimant.
20 (V.T.I.C. Art. 9.48, Sec. 12.)

21 Sec. 2602.258. CERTAIN MONEY AUTHORIZED FOR USE IN PAYING
22 COVERED CLAIM; LIMIT. (a) Money from assessments or guaranty fees
23 is liable only for the difference between the amount of covered
24 claims and the amount of assets marshalled by a receiver or
25 conservator for payment to holders of covered claims.

26 (b) In an ancillary receivership in this state, money from
27 assessments is liable only for the difference between the amount of

1 covered claims and the amount of assets marshalled by receivers in
2 other states for payment of covered claims in this state. (V.T.I.C.
3 Art. 9.48, Secs. 11(a), (b) (part).)

4 Sec. 2602.259. STAY OF PROCEEDINGS; CERTAIN DECISIONS NOT
5 BINDING. (a) To permit the receiver or association to properly
6 defend a pending cause of action, a proceeding in which an impaired
7 title insurance company is a party or is obligated to defend a party
8 in a court in this state, other than a proceeding directly related
9 to the receivership or instituted by the receiver, is stayed for:

10 (1) a six-month period beginning on the later of the
11 date of the designation of impairment or the date an ancillary
12 proceeding is brought in this state; and

13 (2) any subsequent period as determined by the court.

14 (b) If a covered claim arises from a judgment, order,
15 verdict, finding, or other decision based on the default of an
16 impaired title insurance company or its failure to defend an
17 insured, the association on its own behalf or on behalf of the
18 insured may apply to the court or administrator that made the
19 decision to have the decision set aside and may defend the claim on
20 its merits.

21 (c) In a proceeding considering a covered claim, a judgment
22 against an insured taken after the date the delinquency proceeding
23 begins or a conservator is appointed is not evidence of liability or
24 of the amount of damages, and a default or consent judgment against
25 an insured or the impaired title insurance company or a settlement,
26 release, or judgment entered into by the insured or the impaired
27 title insurance company does not bind the association and is not

1 evidence of liability or of the amount of damages in connection with
2 a claim brought against the association or another party under this
3 chapter. (V.T.I.C. Art. 9.48, Secs. 11(c) (part), 20B (part).)

4 Sec. 2602.260. ADMISSIBILITY OF PAYMENT. In a lawsuit
5 brought by a conservator or receiver of an impaired title insurance
6 company or agent to recover assets of the company or agent, the fact
7 that a claim against the company or agent has been or will be paid
8 under this chapter is not admissible and may not be placed before a
9 jury by evidence, argument, or reference. (V.T.I.C. Art. 9.48,
10 Sec. 19(a).)

11 [Sections 2602.261-2602.300 reserved for expansion]

12 SUBCHAPTER G. ASSOCIATION POWERS AND DUTIES RELATING TO
13 COVERED CLAIMS

14 Sec. 2602.301. GENERAL POWERS AND DUTIES OF ASSOCIATION IN
15 CONNECTION WITH PAYMENT OF COVERED CLAIMS. (a) The association
16 shall:

17 (1) investigate a claim brought against the
18 association, the commissioner, or a special deputy receiver
19 appointed under Article 21.28 if the claim involves or may involve
20 the association's rights and obligations under this chapter; and

21 (2) adjust, compromise, settle, and pay a covered
22 claim to the extent of the association's obligation, and deny all
23 other claims.

24 (b) The association may review a settlement, release, or
25 judgment to which an impaired title insurance company or agent or
26 its insured was a party to determine the extent to which the
27 settlement, release, or judgment is contested. (V.T.I.C. Art.

9.48, Sec. 10(e).)

Sec. 2602.302. PAYMENT OF COVERED CLAIMS. (a) The association shall pay covered claims:

(1) existing before the determination of impairment;
or

(2) arising on or before:

(A) the date of cancellation of the impaired title insurance company's policies; or

(B) the claim deadline for covered claims against an impaired agent.

(b) The court in which the receivership proceedings are pending shall set, as applicable:

(1) the date of cancellation of the policies, which may not be later than the fifth anniversary of the date of determination of impairment; or

(2) the claim deadline, which may not be later than the first anniversary of the date of determination of impairment.

(c) Subject to the approval of the commissioner, the association shall establish:

(1) procedures for filing claims with the association;
and

(2) acceptable forms of proof of covered claims.

(d) The association shall pay claims in the order the association considers reasonable, including payment as claims are received from the claimants or in groups or categories of claims.

(e) The association may not pay a claimant an amount exceeding the amount of the claimant's covered claim. (V.T.I.C.

1 Art. 9.48, Secs. 10(a), (b), (f), (g) (part).)

2 Sec. 2602.303. SERVICING FACILITY. (a) The association
3 may handle claims through its employees or through one or more title
4 insurance companies or other persons designated, subject to the
5 approval of the commissioner, as a servicing facility.

6 (b) A title insurance company may decline designation as a
7 servicing facility.

8 (c) The association shall reimburse a servicing facility
9 for:

10 (1) obligations of the association paid by the
11 facility; and

12 (2) expenses incurred by the facility in handling
13 claims for the association. (V.T.I.C. Art. 9.48, Sec. 10(h).)

14 Sec. 2602.304. ADVANCE AS LOAN. Money advanced by the
15 association under this chapter is considered a special fund loan to
16 the impaired title insurance company or agent for payment of
17 covered claims and does not become an asset of the title insurance
18 company or agent. The loan is repayable to the extent money from
19 the title insurance company or agent is available. (V.T.I.C. Art.
20 9.48, Sec. 10(j).)

21 Sec. 2602.305. ASSOCIATION IN PLACE OF IMPAIRED TITLE
22 INSURANCE COMPANY OR AGENT. (a) To the extent of the association's
23 obligation on a covered claim, the association stands in the place
24 of the impaired title insurance company or agent and has all the
25 rights, duties, and obligations of the company or agent as if the
26 company or agent were not impaired.

27 (b) In performing its obligations under this chapter, the

1 association is not considered:

2 (1) to be engaged in the business of insurance;

3 (2) to have assumed or succeeded to a liability of the
4 impaired title insurance company or agent; or

5 (3) to otherwise stand in the place of the impaired
6 title insurance company or agent, including as to whether the
7 association is subject to personal jurisdiction of the courts of
8 another state. (V.T.I.C. Art. 9.48, Sec. 10(d).)

9 Sec. 2602.306. ASSIGNMENT OF CLAIMANT'S RIGHTS. (a) Any
10 cause of action or other right of the holder of a covered claim
11 arising from the occurrence on which the claim is based is assigned
12 to the association on the holder's acceptance of:

13 (1) the association's payment of the claim; or

14 (2) a benefit of a contract by the association
15 providing for reinsurance or assumption of liabilities or for
16 substitution.

17 (b) Rights are assigned to the association under Subsection
18 (a) to the extent of the amount accepted or the value of the benefit
19 provided.

20 (c) The association may assign the rights acquired under
21 this section to the title insurance company executing the
22 reinsurance, assumption, or substitution agreement. (V.T.I.C.
23 Art. 9.48, Sec. 11(d).)

24 Sec. 2602.307. SETTLEMENT BY ASSOCIATION BINDING; PRIORITY
25 OF CLAIM AND EXPENSES. (a) The settlement of a covered claim by the
26 association binds the receiver or statutory successor of an
27 impaired title insurance company.

1 (b) The court shall give the covered claim the same priority
2 against assets of the impaired title insurance company that the
3 claim would have had in the absence of this chapter.

4 (c) The association's expenses in handling claims have the
5 same priority as the receiver's expenses. (V.T.I.C. Art. 9.48,
6 Sec. 11(e).)

7 Sec. 2602.308. REPORT TO RECEIVER. The association shall
8 periodically file with the receiver of an impaired title insurance
9 company a statement of covered claims paid by the association and an
10 estimate of claims anticipated against the association. The
11 statement preserves the rights of the association against the
12 assets of the company. (V.T.I.C. Art. 9.48, Sec. 11(f).)

13 [Sections 2602.309-2602.350 reserved for expansion]

14 SUBCHAPTER H. CONSERVATOR OR RECEIVER POWERS AND DUTIES
15 RELATING TO COVERED CLAIMS

16 Sec. 2602.351. DETERMINATION OF CONSERVATOR CONCERNING
17 REINSURANCE, ASSUMPTION, OR SUBSTITUTION. A conservator appointed
18 to handle the affairs of an impaired title insurance company or
19 agent shall determine whether covered claims should or can be
20 provided for in whole or in part by reinsurance, assumption, or
21 substitution. (V.T.I.C. Art. 9.48, Sec. 11(b) (part).)

22 Sec. 2602.352. NOTICE OF DETERMINATION CONCERNING ACTUAL
23 PAYMENT. (a) On determination by the conservator that covered
24 claims should be actually paid, the conservator shall give notice
25 of the determination to holders of covered claims.

26 (b) The conservator shall mail the notice to each holder of
27 a covered claim at the most recent address shown in the impaired

1 title insurance company's or agent's records, except that if those
2 records do not show the claimant's address the conservator may give
3 notice by publication in a newspaper of general circulation.

4 (c) The notice must state a date, not earlier than the 91st
5 day after the date of the mailing or publication of the notice,
6 before which the claimant must file a claim with the conservator.
7 (V.T.I.C. Art. 9.48, Sec. 11(b) (part).)

8 Sec. 2602.353. FILING OF COVERED CLAIM. The conservator
9 may require in whole or in part that claimants file:

10 (1) sworn claim forms; and
11 (2) additional information or evidence reasonably
12 necessary for the conservator to determine the legality of or
13 amount due under a covered claim. (V.T.I.C. Art. 9.48, Sec. 11(b)
14 (part).)

15 Sec. 2602.354. CLAIM BY PERSON WITH CAUSE OF ACTION AGAINST
16 INSURED. (a) On determination by the conservator that covered
17 claims should be actually paid or on order of the court to the
18 receiver to give notice for the filing of claims, a person having a
19 cause of action that constitutes a covered claim against an insured
20 of the impaired title insurance company under a title insurance
21 policy issued or assumed by the company may file the claim with the
22 receiver or conservator, regardless of whether the claim is
23 unliquidated or undetermined.

24 (b) A claim under this section may be approved as a covered
25 claim if:

26 (1) it may be reasonably inferred from the proof
27 presented that the claimant would be able to obtain a judgment on

1 the cause of action against the insured;

2 (2) the claimant provides suitable proof that no valid
3 claim exists against the impaired title insurance company arising
4 from the cause of action other than claims already made; and

5 (3) the total liability of the impaired title
6 insurance company to all claimants under the same title insurance
7 policy does not exceed the amount of the company's total liability
8 if the company were not in liquidation, rehabilitation, or
9 conservation. (V.T.I.C. Art. 9.48, Sec. 11(c) (part).)

10 Sec. 2602.355. REPORT TO ASSOCIATION. (a) A receiver of an
11 impaired title insurance company or agent shall periodically submit
12 a list of claims to the association or a similar organization in
13 another state.

14 (b) Notice of a claim to the receiver is considered notice
15 to the association. (V.T.I.C. Art. 9.48, Sec. 10(g) (part).)

16 [Sections 2602.356-2602.400 reserved for expansion]

17 SUBCHAPTER I. OPERATION OF IMPAIRED TITLE INSURANCE

18 COMPANY OR AGENT

19 Sec. 2602.401. ISSUANCE OR RENEWAL OF POLICIES. (a) If an
20 assessment has been made under this chapter for an impaired title
21 insurance company or association funds have been provided for the
22 company, the company, on release from the conservatorship or
23 receivership, may not issue a new or renewal insurance policy until
24 the company:

25 (1) has repaid pro rata in full to each holder of a
26 participation receipt the assessment amount paid by the receipt
27 holder or its assignee; and

1 (2) has repaid in full the amount of guaranty fees paid
2 by the association.

3 (b) If an assessment has been made under this chapter for an
4 impaired agent or guaranty fees have been provided for the agent,
5 the agent, on release from the conservatorship or receivership, may
6 not issue a new or renewal insurance policy until the agent has
7 repaid in full the amount of guaranty fees paid by the association.

8 (c) Notwithstanding Subsections (a) and (b), on
9 application of the association and after hearing, the commissioner
10 may permit the impaired title insurance company or agent to issue
11 new policies as provided by a plan of operation for repayment. In
12 approving the plan, the commissioner may restrict the issuance of
13 new or renewal policies as the commissioner considers necessary to
14 implement the plan.

15 (d) Not later than the 11th day before the date of a hearing
16 under Subsection (c), the commissioner shall give notice of the
17 hearing to the association. The commissioner shall give 10 days'
18 notice of the hearing to title insurance companies to whom
19 participation receipts were issued for an assessment made for the
20 benefit of the released title insurance company. The association
21 and title insurance companies are entitled to appear at and
22 participate in the hearing.

23 (e) Money recovered against an impaired title insurance
24 company under this section shall be repaid to the title insurance
25 companies that paid assessments in relation to the impaired title
26 insurance company on return of the participation receipt.

27 (V.T.I.C. Art. 9.48, Secs. 13, 23(i).)

1 Sec. 2602.402. DISTRIBUTIONS TO SHAREHOLDERS AND
2 AFFILIATES. (a) An impaired or insolvent title insurance company
3 may not make a distribution to shareholders until the association
4 has recovered the total amount of valid claims for money spent in
5 exercising the association's powers and performing the
6 association's duties under this chapter with respect to that
7 company, plus interest on that amount.

8 (b) Except as otherwise provided by this section, the
9 receiver appointed under an order of receivership of a title
10 insurance company domiciled in this state may recover on behalf of
11 the company from an affiliate that controlled the company the
12 amount of a distribution, other than a stock dividend the company
13 paid on its common stock, made during the five years preceding the
14 date of the petition for liquidation or rehabilitation.

15 (c) A person who was an affiliate that controlled the title
16 insurance company when the distribution described by Subsection (b)
17 was paid is liable for the amount of the distribution received. A
18 person who was an affiliate that controlled the title insurance
19 company when the distribution was declared is liable for the amount
20 of the distribution the affiliate would have received if the
21 distribution had been paid immediately. Two or more persons liable
22 for the same distribution are jointly and severally liable. If a
23 person liable under this subsection is insolvent, all of the
24 affiliates that controlled the insolvent person when the
25 distribution was paid are jointly and severally liable for any
26 resulting deficiency in the amount recovered from the insolvent
27 person.

1 (d) The maximum amount recoverable under Subsections (b)
2 and (c) is the amount needed in excess of all other available assets
3 of the insolvent title insurance company to pay the company's
4 contractual obligations.

5 (e) The receiver may not recover a distribution under
6 Subsection (b) if the title insurance company shows that:

7 (1) the distribution was lawful and reasonable on the
8 date of payment; and

9 (2) the company did not know and could not reasonably
10 have known that the distribution might adversely affect the ability
11 of the company to fulfill its contractual obligations. (V.T.I.C.
12 Art. 9.48, Secs. 23(c), (d), (e), (f), (g), (h).)

13 Sec. 2602.403. ASSETS ATTRIBUTABLE TO COVERED POLICIES.

14 (a) For the purposes of this section, assets attributable to
15 covered policies are the proportion of the assets that the reserves
16 that should have been established for the covered policies bear to
17 the reserves that should have been established for all insurance
18 policies written by the impaired or insolvent title insurance
19 company.

20 (b) To perform its obligations under this chapter, the
21 association is considered a creditor of the impaired or insolvent
22 title insurance company to the extent of assets attributable to
23 covered policies, less any amount that the association recovers as
24 a subrogee under this chapter.

25 (c) Assets of the impaired or insolvent title insurance
26 company attributable to covered policies shall be used to continue
27 all covered policies and pay all contractual obligations of the

1 impaired or insolvent company as required by this chapter.
2 (V.T.I.C. Art. 9.48, Sec. 23(b).)

3 [Chapters 2603-2650 reserved for expansion]

4 SUBTITLE D. TITLE INSURANCE PROFESSIONALS

5 CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

6 SUBCHAPTER A. TITLE INSURANCE AGENT'S LICENSE

7 Sec. 2651.001. LICENSE AND BOND OR DEPOSIT REQUIRED

8 Sec. 2651.002. LICENSE APPLICATION

9 Sec. 2651.003. LICENSE AND RENEWAL FEES

10 Sec. 2651.004. LICENSE ISSUANCE

11 Sec. 2651.005. DUPLICATE LICENSE

12 Sec. 2651.006. LICENSE TERM

13 Sec. 2651.007. LICENSE RENEWAL

14 Sec. 2651.008. RECORDS OF AGENTS

15 Sec. 2651.009. MULTIPLE APPOINTMENTS

16 Sec. 2651.010. SUSPENSION OF LICENSE

17 Sec. 2651.011. PRIVILEGED COMMUNICATIONS

18 [Sections 2651.012-2651.050 reserved for expansion]

19 SUBCHAPTER B. DIRECT OPERATION LICENSE

20 Sec. 2651.051. LICENSE REQUIRED

21 Sec. 2651.052. LICENSE APPLICATION

22 Sec. 2651.053. LICENSE AND RENEWAL FEES

23 Sec. 2651.054. LICENSE TERM

24 Sec. 2651.055. LICENSE RENEWAL

25 Sec. 2651.056. CEASING OPERATION OF ABSTRACT PLANT;

26 REQUEST FOR LICENSE CANCELLATION

27 Sec. 2651.057. AUTOMATIC TERMINATION OF LICENSES

1 Sec. 2651.058. RECORDS OF DIRECT OPERATIONS

2 Sec. 2651.059. USE OF AGENTS NOT PROHIBITED

3 [Sections 2651.060-2651.100 reserved for expansion]

4 SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

5 Sec. 2651.101. BOND REQUIRED

6 Sec. 2651.102. ALTERNATIVE TO BOND

7 Sec. 2651.103. EXAMINATION OF LOSS COVERED BY BOND OR
8 DEPOSIT

9 Sec. 2651.104. INVESTIGATION BY ATTORNEY GENERAL

10 [Sections 2651.105-2651.150 reserved for expansion]

11 SUBCHAPTER D. ANNUAL AUDIT

12 Sec. 2651.151. ANNUAL AUDIT OF TRUST FUND ACCOUNTS:
13 TITLE INSURANCE AGENTS AND DIRECT
14 OPERATIONS

15 Sec. 2651.152. ANNUAL AUDIT OF TRUST FUND ACCOUNTS:
16 TITLE INSURANCE COMPANIES

17 Sec. 2651.153. RULES

18 Sec. 2651.154. PERFORMANCE OF AUDIT BY PUBLIC ACCOUNTANT

19 Sec. 2651.155. CONFIDENTIALITY OF AUDIT

20 Sec. 2651.156. FAILURE TO RECEIVE AUDIT REPORT FROM
21 AGENTS OR DIRECT OPERATIONS

22 Sec. 2651.157. ENFORCEMENT; HEARING

23 [Sections 2651.158-2651.200 reserved for expansion]

24 SUBCHAPTER E. GENERAL REGULATION OF TITLE INSURANCE
25 AGENTS AND DIRECT OPERATIONS

26 Sec. 2651.201. LICENSE SURRENDER OR FORFEITURE

27 Sec. 2651.202. TRUST FUND ACCOUNT DISBURSEMENTS

1 Sec. 2651.203. DISCLOSURE OF OWNERSHIP AND PREMIUM
2 INFORMATION

3 Sec. 2651.204. CONTINUING EDUCATION

4 [Sections 2651.205-2651.250 reserved for expansion]

5 SUBCHAPTER F. TITLE INSURANCE COMPANY POWERS AND DUTIES
6 REGARDING TITLE INSURANCE AGENTS

7 Sec. 2651.251. EXAMINATION OF TRUST FUND ACCOUNTS BY
8 TITLE INSURANCE COMPANY

9 Sec. 2651.252. SPECIAL REPORTS

10 Sec. 2651.253. AUDIT OF UNUSED FORMS

11 [Sections 2651.254-2651.300 reserved for expansion]

12 SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

13 Sec. 2651.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
14 ACTION

15 Sec. 2651.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL,
16 OR REVOCATION

17 CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

18 SUBCHAPTER A. TITLE INSURANCE AGENT'S LICENSE

19 Sec. 2651.001. LICENSE AND BOND OR DEPOSIT REQUIRED. (a)
20 An individual, firm, association, or corporation may not act in
21 this state as a title insurance agent for a title insurance company
22 unless the individual or entity:

23 (1) holds a license as an agent issued by the
24 department; and

25 (2) maintains a surety bond or deposit required under
26 Subchapter C.

27 (b) A title insurance company may not allow or permit an

1 individual, firm, association, or corporation to act as its agent
2 in this state unless the individual or entity complies with this
3 section. (V.T.I.C. Art. 9.35.)

4 Sec. 2651.002. LICENSE APPLICATION. (a) Before an initial
5 license is issued to an individual, firm, association, or
6 corporation to act as an agent in this state for a title insurance
7 company, the company must file an application for an agent's
8 license with the department on forms provided by the department.

9 (b) The application must be:

10 (1) accompanied by a nonrefundable license fee; and
11 (2) signed and sworn to by the title insurance company
12 and by the proposed agent.

13 (c) The completed application must state that:

14 (1) the proposed agent is:
15 (A) an individual who is a bona fide resident of
16 this state;

17 (B) an association or firm composed only of Texas
18 residents; or

19 (C) a Texas corporation or a foreign corporation
20 authorized to engage in business in this state;

21 (2) the proposed agent, including a corporation's
22 managerial personnel, if applicable, has reasonable experience or
23 instruction in the field of title insurance;

24 (3) the title insurance company:
25 (A) knows that the proposed agent has a good
26 business reputation and is worthy of the public trust; and

27 (B) is unaware of any fact or condition that

1 disqualifies the proposed agent from receiving a license; and

2 (4) the proposed agent qualifies as a title insurance
3 agent under this chapter. (V.T.I.C. Art. 9.36, Sec. 1(a) (part).)

4 Sec. 2651.003. LICENSE AND RENEWAL FEES. (a) The
5 department shall prescribe the license fee in an amount not to
6 exceed \$50.

7 (b) License fees, and renewal fees collected under this
8 subchapter, shall be deposited to the credit of the Texas
9 Department of Insurance operating account to be used by the
10 department to enforce this chapter and any other law of this state
11 that regulates title insurance agents. (V.T.I.C. Art. 9.36, Sec.
12 1(a) (part).)

13 Sec. 2651.004. LICENSE ISSUANCE. The department shall
14 issue a license if the department determines, based on the
15 application and the department's investigation, that the
16 requirements of Section 2651.002 are satisfied. (V.T.I.C. Art.
17 9.36, Sec. 1(b).)

18 Sec. 2651.005. DUPLICATE LICENSE. (a) The department
19 shall collect in advance a fee from a title insurance agent who
20 requests a duplicate license.

21 (b) The department shall prescribe the fee in an amount not
22 to exceed \$20. (V.T.I.C. Art. 9.36, Sec. 1(c).)

23 Sec. 2651.006. LICENSE TERM. Unless a system of staggered
24 license renewal is adopted under Section 4003.002, a license issued
25 under this subchapter expires on June 1 after the second
26 anniversary of the date of issuance. (V.T.I.C. Art. 9.36, Sec.
27 2(b).)

1 Sec. 2651.007. LICENSE RENEWAL. (a) A title insurance
2 agent may renew a license by:

3 (1) filing a completed license renewal application
4 form with the department; and

5 (2) paying the nonrefundable license renewal fee to
6 the department.

7 (b) The department shall prescribe the license renewal
8 application form.

9 (c) The department shall prescribe the license renewal fee
10 in an amount not to exceed \$50. (V.T.I.C. Art. 9.36, Sec. 2(a).)

11 Sec. 2651.008. RECORDS OF AGENTS. The department shall
12 maintain a record of the name and address of each title insurance
13 agent licensed by the department in a manner that ensures that the
14 agents appointed by any company authorized to engage in the
15 business of title insurance in this state may be conveniently
16 ascertained and inspected by any person on request. (V.T.I.C. Art.
17 9.36, Sec. 2(c).)

18 Sec. 2651.009. MULTIPLE APPOINTMENTS. (a) A licensed
19 title insurance agent may be appointed to represent additional
20 title insurance companies.

21 (b) Any additional title insurance company must notify the
22 department of the appointment in the manner prescribed by the
23 department. The agent must include with the notice a nonrefundable
24 fee for each additional appointment. The department shall
25 prescribe the fee in an amount not to exceed \$16.

26 (c) The appointment is effective on the eighth day following
27 the date the department receives the completed notice of

1 appointment and the fee, unless the department rejects the
2 appointment. If the department rejects the appointment, the
3 department shall state in writing the reasons for rejection not
4 later than the seventh day after the date on which the department
5 receives the completed notice of appointment.

6 (d) A title insurance company may not permit an agent
7 appointed by the company to write, sign, or deliver title insurance
8 until the agent's appointment is effective.

9 (e) The appointment remains effective, without the
10 necessity of renewal, until the appointment:

11 (1) is terminated by the title insurance company as
12 provided by this section; or

13 (2) is otherwise terminated under this subchapter.

14 (f) A renewal license issued to an agent authorizes the
15 agent to represent and act for the title insurance companies for
16 which the agent holds appointments until the appointments are
17 terminated, and the agent is considered to be the agent of the
18 appointing companies for purposes of this subchapter.

19 (g) When a title insurance company terminates the
20 appointment of an agent, the company shall immediately file with
21 the department a statement that contains:

22 (1) the facts relating to the termination of the
23 appointment; and

24 (2) the effective date and reason for the termination.

25 (h) On receipt of the statement, the department shall
26 terminate the appointment of the agent to represent that title
27 insurance company in this state. (V.T.I.C. Art. 9.36, Secs. 3(a),

1 (b), (c).)

2 Sec. 2651.010. SUSPENSION OF LICENSE. The department shall
3 suspend the license of a title insurance agent during any period in
4 which the agent does not have a valid appointment. The department
5 shall end the suspension when the department receives an acceptable
6 notice of a valid appointment. (V.T.I.C. Art. 9.36, Sec. 4.)

7 Sec. 2651.011. PRIVILEGED COMMUNICATIONS. Any
8 information, including a document, record, or statement, required
9 to be made or disclosed to the department under this subchapter,
10 other than Section 2651.001, is:

11 (1) a privileged communication; and

12 (2) not admissible in evidence in a court action or
13 proceeding except under a subpoena issued by a court of record.
14 (V.T.I.C. Art. 9.36, Sec. 3(d).)

15 [Sections 2651.012-2651.050 reserved for expansion]

16 SUBCHAPTER B. DIRECT OPERATION LICENSE

17 Sec. 2651.051. LICENSE REQUIRED. (a) A title insurance
18 company may not own or lease and operate an abstract plant or
19 participate in a bona fide joint abstract plant operation in a
20 county in this state unless the company holds a license as a direct
21 operation issued by the department for that county.

22 (b) A title insurance company may not write, sign, or
23 deliver title insurance in a county in which the company operates an
24 abstract plant until the department has issued a direct operation
25 license to the company. (V.T.I.C. Art. 9.36A, Secs. A, C (part).)

26 Sec. 2651.052. LICENSE APPLICATION. (a) Before a direct
27 operation license is issued to a title insurance company, the

1 company must file an application for a direct operation license on
2 forms provided by the department.

3 (b) The application must be:

4 (1) accompanied by a nonrefundable license fee; and

5 (2) signed and sworn to by the title insurance
6 company.

7 (c) The completed application must state that:

8 (1) the title insurance company is a Texas corporation
9 or a foreign corporation holding a certificate of authority to
10 insure titles to real property in this state and meets the
11 requirements of this title; and

12 (2) the abstract plant to be licensed:

13 (A) complies with department requirements
14 relating to abstract plants; and

15 (B) has been approved by the department.
16 (V.T.I.C. Art. 9.36A, Sec. B (part).)

17 Sec. 2651.053. LICENSE AND RENEWAL FEES. (a) The
18 department shall prescribe the license fee in an amount not to
19 exceed \$50.

20 (b) License fees, and renewal fees collected under this
21 subchapter, shall be deposited to the credit of the Texas
22 Department of Insurance operating account to be used by the
23 department to enforce this chapter and the laws of this state that
24 regulate title insurance agents and title insurance companies.
25 (V.T.I.C. Art. 9.36A, Sec. B (part).)

26 Sec. 2651.054. LICENSE TERM. Unless a system of staggered
27 license renewal is adopted, a license issued under this subchapter

1 expires on the second June 1 following the date of issuance.
2 (V.T.I.C. Art. 9.36A, Sec. C (part).)

3 Sec. 2651.055. LICENSE RENEWAL. (a) On or before the
4 expiration date of a license issued under this subchapter, a title
5 insurance company may renew the license by:

6 (1) certifying to the department each county and
7 address at which the company operates the abstract plant for each
8 license to be renewed;

9 (2) filing a completed renewal application; and

10 (3) paying a nonrefundable license renewal fee for
11 each license.

12 (b) The department shall provide the forms used under this
13 section.

14 (c) The department shall prescribe the license renewal fee
15 in an amount not to exceed \$50.

16 (d) If a license has been expired for 90 days or less, the
17 license holder may renew the license by paying to the department the
18 required nonrefundable renewal fee and a nonrefundable fee equal to
19 one-half of the original license fee.

20 (e) If a license has been expired for more than 90 days, the
21 license may not be renewed. (V.T.I.C. Art. 9.36A, Sec. C (part).)

22 Sec. 2651.056. CEASING OPERATION OF ABSTRACT PLANT; REQUEST
23 FOR LICENSE CANCELLATION. If a title insurance company ceases to
24 operate a licensed abstract plant, the company shall immediately
25 notify the department in writing and request cancellation of the
26 license. (V.T.I.C. Art. 9.36A, Sec. C (part).)

27 Sec. 2651.057. AUTOMATIC TERMINATION OF LICENSES. If a

1 title insurance company surrenders the company's certificate of
2 authority or if the certificate of authority is revoked by the
3 department, all licenses of the company's abstract plants
4 automatically terminate. (V.T.I.C. Art. 9.36A, Sec. C (part).)

5 Sec. 2651.058. RECORDS OF DIRECT OPERATIONS. The
6 department shall maintain a record of the county and address of each
7 location at which a title insurance company operates an abstract
8 plant in a manner that ensures that the abstract plants may be
9 conveniently ascertained and inspected by any person on request.
10 (V.T.I.C. Art. 9.36A, Sec. C (part).)

11 Sec. 2651.059. USE OF AGENTS NOT PROHIBITED. This
12 subchapter does not prohibit a title insurance company from issuing
13 title insurance through a licensed title insurance agent.
14 (V.T.I.C. Art. 9.36A, Sec. C (part).)

15 [Sections 2651.060-2651.100 reserved for expansion]

16 SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

17 Sec. 2651.101. BOND REQUIRED. (a) Each licensed title
18 insurance agent and direct operation shall make, file, and pay for a
19 surety bond payable to the department and issued by a corporate
20 surety company authorized to write surety bonds in this state. The
21 bond shall obligate the principal and surety to pay for any
22 pecuniary loss sustained by:

23 (1) any participant in an insured real property
24 transaction through an act of fraud, dishonesty, theft,
25 embezzlement, or wilful misapplication by a title insurance agent
26 or direct operation; or

27 (2) the department as a result of any administrative

1 expense incurred in a receivership of a title insurance agent or
2 direct operation.

3 (b) The amount of the bond must be the greater of:

4 (1) \$10,000; or

5 (2) an amount equal to 10 percent of the gross premium
6 written by the title insurance agent or direct operation in
7 accordance with the latest statistical report to the department but
8 not to exceed \$100,000. (V.T.I.C. Art. 9.38, Sec. (a) (part).)

9 Sec. 2651.102. ALTERNATIVE TO BOND. (a) Instead of the
10 bond required by Section 2651.101, a title insurance agent or
11 direct operation may deposit with the department:

12 (1) cash;

13 (2) irrevocable letters of credit issued by a
14 financial institution in this state that is insured by an agency of
15 the United States; or

16 (3) securities approved by the department.

17 (b) The cash, letters of credit, or securities deposited
18 under this section are subject to the conditions required for a
19 bond under Section 2651.101. (V.T.I.C. Art. 9.38, Sec. (a)
20 (part).)

21 Sec. 2651.103. EXAMINATION OF LOSS COVERED BY BOND OR
22 DEPOSIT. (a) At any time it appears that a loss covered by a bond
23 or deposit has occurred, the department may require the title
24 insurance agent or direct operation to appear in Travis County,
25 with records the department determines to be proper, for an
26 examination.

27 (b) The department shall specify a date for the examination

1 that is not earlier than the 10th day or later than the 15th day
2 after the date of service of notice of the requirement to appear.

3 (c) If after the examination the department determines that
4 a loss covered by the bond or deposit has occurred, the department
5 shall immediately notify the surety on the bond, if applicable, and
6 prepare a written statement of the facts of the loss and deliver the
7 statement to the attorney general. (V.T.I.C. Art. 9.38, Sec. (b)
8 (part).)

9 Sec. 2651.104. INVESTIGATION BY ATTORNEY GENERAL. (a) On
10 receipt of a written statement under Section 2651.103, the attorney
11 general shall investigate the charges and, on determining that a
12 loss covered by the bond or deposit has occurred, shall enforce the
13 liability by collecting against the deposited cash or securities or
14 by filing suit on the bond.

15 (b) A suit brought under this section shall be filed in the
16 name of the department in Travis County for the benefit of all
17 parties who have suffered any loss covered by the bond or deposit.
18 (V.T.I.C. Art. 9.38, Sec. (b) (part).)

19 [Sections 2651.105-2651.150 reserved for expansion]

20 SUBCHAPTER D. ANNUAL AUDIT

21 Sec. 2651.151. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE
22 INSURANCE AGENTS AND DIRECT OPERATIONS. (a) Each title insurance
23 agent and direct operation shall have an annual audit made of trust
24 fund accounts. The agent or direct operation shall pay for the
25 audit.

26 (b) Not later than the 90th day after the date of the end of
27 the agent's or direct operation's fiscal year, the agent or direct

1 operation shall send by certified mail, postage prepaid, to the
2 department one copy of the audit report with a transmittal letter.
3 The agent shall also send a copy of the audit report and transmittal
4 letter to each title insurance company that the agent represents.
5 (V.T.I.C. Art. 9.39, Sec. (a).)

6 Sec. 2651.152. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE
7 INSURANCE COMPANIES. (a) Each title insurance company shall have
8 an annual audit made of trust fund accounts for each county in which
9 it operates in its own name. The company shall pay for the audit.

10 (b) Not later than the 90th day after the date of the end of
11 the title insurance company's fiscal year, the company shall send
12 by certified mail, postage prepaid, to the department one copy of
13 the audit report. (V.T.I.C. Art. 9.39, Sec. (b).)

14 Sec. 2651.153. RULES. The commissioner by rule shall
15 adopt:

- 16 (1) the standards for an audit; and
17 (2) the form of the required audit report. (V.T.I.C.
18 Art. 9.39, Sec. (c).)

19 Sec. 2651.154. PERFORMANCE OF AUDIT BY PUBLIC ACCOUNTANT.
20 An audit required under this subchapter must be performed by an
21 independent certified public accountant or licensed public
22 accountant, or a firm composed of either. (V.T.I.C. Art. 9.39, Sec.
23 (d).)

24 Sec. 2651.155. CONFIDENTIALITY OF AUDIT. The commissioner
25 may classify an audit report that is filed with the department by a
26 title insurance company under this subchapter as confidential and
27 privileged. (V.T.I.C. Art. 9.39, Sec. (f).)

1 Sec. 2651.156. FAILURE TO RECEIVE AUDIT REPORT FROM AGENTS
2 OR DIRECT OPERATIONS. If a title insurance company fails to receive
3 an audit report from any of the company's agents or direct
4 operations in the specified period required by Section 2651.151,
5 the company shall report that failure to the department not later
6 than the 30th day after the expiration of the specified period.
7 (V.T.I.C. Art. 9.39, Sec. (e).)

8 Sec. 2651.157. ENFORCEMENT; HEARING. (a) After notice and
9 hearing, the department may revoke the license or certificate of
10 authority of a title insurance agent, direct operation, or title
11 insurance company that:

12 (1) fails to furnish an audit report in the time
13 required; or

14 (2) furnishes an audit report that reveals any
15 irregularity, including a shortage, or any practice not in keeping
16 with sound, honest business practices.

17 (b) The notice must be provided to the agent, the direct
18 operation, or each title insurance company involved.

19 (c) At a hearing under this section, the agent, direct
20 operation, or title insurance company may offer evidence explaining
21 or excusing a failure or irregularity. (V.T.I.C. Art. 9.39, Sec.
22 (g).)

23 [Sections 2651.158-2651.200 reserved for expansion]

24 SUBCHAPTER E. GENERAL REGULATION OF TITLE INSURANCE

25 AGENTS AND DIRECT OPERATIONS

26 Sec. 2651.201. LICENSE SURRENDER OR FORFEITURE. (a) A
27 title insurance agent or direct operation may voluntarily surrender

1 at any time a license issued under this chapter by giving notice to:

2 (1) the department; and

3 (2) the affected title insurance company.

4 (b) A title insurance agent or direct operation that
5 terminates the agency contract with a title insurance company
6 automatically forfeits the license under that company.

7 (c) A surrender or forfeiture of a license under this
8 section does not affect the culpability of the license holder for
9 conduct committed before the effective date of the surrender or
10 forfeiture. The department may institute a disciplinary proceeding
11 against the former license holder for conduct committed before the
12 effective date of the surrender or forfeiture. (V.T.I.C. Art.
13 9.37, Secs. A, F.)

14 Sec. 2651.202. TRUST FUND ACCOUNT DISBURSEMENTS. (a) A
15 title insurance company, title insurance agent, or direct operation
16 may not disburse funds from a trust fund account until good funds
17 related to the transaction have been received and deposited in the
18 account in amounts sufficient to fund any disbursements from the
19 transaction.

20 (b) A title insurance company, title insurance agent, or
21 direct operation is not liable for a violation of this section if
22 the violation:

23 (1) was not intentional; and

24 (2) resulted from a bona fide error despite the
25 maintenance of procedures reasonably adopted to avoid the error.

26 (c) The commissioner shall adopt rules and definitions to
27 implement this section. (V.T.I.C. Art. 9.39A, Secs. (a) (part),

1 (b), (c) (part).)

2 Sec. 2651.203. DISCLOSURE OF OWNERSHIP AND PREMIUM
3 INFORMATION. (a) A title insurance agent who receives a portion
4 of a premium shall disclose to each purchaser of a title insurance
5 policy or other title insurance form the following:

6 (1) each shareholder, owner, or partner owning or
7 controlling at least one percent of the agent;

8 (2) each shareholder, owner, or partner owning or
9 controlling at least 10 percent of an entity that owns or controls
10 at least one percent of the agent;

11 (3) each person who is not a full-time employee of the
12 agent and who receives a portion of the premium for services
13 performed on behalf of the agent in connection with the issuance of
14 a title insurance form; and

15 (4) the amount of premium that a person disclosed in
16 Subdivision (3) receives.

17 (b) The department shall prescribe the form of the
18 disclosure required by this section. (V.T.I.C. Art. 9.38, Sec.
19 (c).)

20 Sec. 2651.204. CONTINUING EDUCATION. (a) To protect the
21 public and to preserve and improve the competence of license
22 holders, the department shall require as a condition of holding a
23 title insurance agent license that the license holder enroll in and
24 attend or teach continuing education consisting of class
25 instruction, lectures, seminars, or other forms of education
26 approved by the department for title insurance agents.

27 (b) The department shall prescribe the required number of

1 hours of continuing education, not to exceed 15 hours in each
2 two-year license period.

3 (c) Continuing education instruction must be designed to
4 refresh the license holder's understanding of:

5 (1) basic principles and coverages relating to title
6 insurance;

7 (2) recent and prospective changes in those principles
8 and coverages;

9 (3) applicable rules of the commissioner and laws;

10 (4) the proper conduct of the license holder's
11 business; and

12 (5) the duties and responsibilities of the license
13 holder.

14 (d) The department may permit a license holder to complete
15 an equivalent course of study and instruction by mail if, because of
16 the remote location of the license holder's residence or business,
17 the license holder is unable to attend educational sessions with
18 reasonable convenience.

19 (e) On written request by the license holder, the department
20 may extend the time for the license holder to comply with the
21 requirements of this section or may exempt the license holder from
22 all or part of the requirements for a license period if the
23 department determines that the license holder is unable to comply
24 with the requirements because of illness, medical disability, or
25 another extenuating circumstance beyond the control of the license
26 holder. The commissioner shall prescribe the criteria for an
27 extension or exemption by rule.

1 (f) The commissioner shall adopt rules to administer this
2 section. (V.T.I.C. Art. 9.58, Secs. A (part), B, C, D, E.)

3 [Sections 2651.205-2651.250 reserved for expansion]

4 SUBCHAPTER F. TITLE INSURANCE COMPANY POWERS AND DUTIES REGARDING
5 TITLE INSURANCE AGENTS

6 Sec. 2651.251. EXAMINATION OF TRUST FUND ACCOUNTS BY TITLE
7 INSURANCE COMPANY. (a) A title insurance company may examine, at
8 any time, the trust fund accounts and related records of the
9 company's title insurance agents through the company's examiners or
10 auditors or through independent certified public accountants
11 commissioned by the company.

12 (b) The title insurance company shall pay for each
13 examination. (V.T.I.C. Art. 9.40 (part).)

14 Sec. 2651.252. SPECIAL REPORTS. A title insurance company
15 may require special reports from the company's title insurance
16 agents regarding any of its transactions. (V.T.I.C. Art. 9.40
17 (part).)

18 Sec. 2651.253. AUDIT OF UNUSED FORMS. (a) A title
19 insurance company shall periodically audit the unused forms in the
20 possession of each of the company's title insurance agents to
21 determine that all used forms have been reported to the company.

22 (b) A title insurance company shall conduct an audit
23 required by this section at least once every two years.

24 (c) A report of each audit conducted under this section
25 shall be made to the department. (V.T.I.C. Art. 9.40 (part).)

26 [Sections 2651.254-2651.300 reserved for expansion]

27 SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

1 Sec. 2651.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
2 ACTION. The department may deny an application for a license or
3 discipline a title insurance agent or direct operation under
4 Sections 4005.102, 4005.103, and 4005.104 if the department
5 determines that the applicant or license holder has:

6 (1) wilfully violated this title;
7 (2) intentionally made a material misstatement in the
8 license application;

9 (3) obtained or attempted to obtain the license by
10 fraud or misrepresentation;

11 (4) misappropriated or converted to the applicant's or
12 license holder's own use or illegally withheld money belonging to a
13 title insurance company, an insured, or another person;

14 (5) been guilty of fraudulent or dishonest practices;

15 (6) materially misrepresented the terms and
16 conditions of a title insurance policy or contract; or

17 (7) failed to maintain:

18 (A) a separate and distinct accounting of escrow
19 funds; and

20 (B) an escrow bank account or accounts separate
21 and apart from all other accounts. (V.T.I.C. Art. 9.37, Sec. B.)

22 Sec. 2651.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL,
23 OR REVOCATION. (a) An applicant whose license application has been
24 denied or refused or a license holder whose license has been revoked
25 under this subchapter may not file another application for a
26 license as a title insurance agent or direct operation before the
27 first anniversary of:

(1) the effective date of the denial, refusal, or revocation; or

(2) the date of a final court order affirming the denial, refusal, or revocation if judicial review is sought.

(b) A license application filed after the time required by this section may be denied by the department unless the applicant shows good cause why the denial, refusal, or revocation should not be a bar to the issuance of a license. (V.T.I.C. Art. 9.37, Sec. D.)

CHAPTER 2652. ESCROW OFFICERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2652.001. LICENSE AND BOND OR DEPOSIT REQUIRED

Sec. 2652.002. EMPLOYMENT OF ESCROW OFFICER

Sec. 2652.003. ATTORNEY ACTING AS ESCROW OFFICER

Sec. 2652.004. TRUST FUND ACCOUNT DISBURSEMENTS

Sec. 2652.005. ESCROW ACCOUNT AUDIT

Sec. 2652.006. RECORD OF ESCROW OFFICERS

[Sections 2652.007-2652.050 reserved for expansion]

SUBCHAPTER B. LICENSE APPLICATION AND RENEWAL

Sec. 2652.051. LICENSE APPLICATION

Sec. 2652.052. LICENSE AND RENEWAL FEES

Sec. 2652.053. LICENSE ISSUANCE

Sec. 2652.054. DUPLICATE LICENSE

Sec. 2652.055. LICENSE TERM

Sec. 2652.056. AUTOMATIC TERMINATION OF LICENSE

Sec. 2652.057. LICENSE SURRENDER OR FORFEITURE

Sec. 2652.058. CONTINUING EDUCATION

[Sections 2652.059-2652.100 reserved for expansion]

SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

Sec. 2652.101. BOND REQUIRED

Sec. 2652.102. ALTERNATIVE TO BOND

Sec. 2652.103. AMOUNT OF BOND OR DEPOSIT

Sec. 2652.104. EXAMINATION OF LOSS COVERED BY BOND

OR DEPOSIT

Sec. 2652.105. INVESTIGATION BY ATTORNEY GENERAL

[Sections 2652.106-2652.150 reserved for expansion]

SUBCHAPTER D. DUTIES OF TITLE INSURANCE AGENTS AND DIRECT

OPERATIONS REGARDING ESCROW OFFICERS

Sec. 2652.151. LIST OF ESCROW OFFICERS

Sec. 2652.152. RENEWAL

Sec. 2652.153. NOTICE OF TERMINATION

[Sections 2652.154-2652.200 reserved for expansion]

SUBCHAPTER E. LICENSE DENIAL AND DISCIPLINARY ACTION

Sec. 2652.201. GROUNDS FOR LICENSE DENIAL OR

DISCIPLINARY ACTION

Sec. 2652.202. LICENSE APPLICATION AFTER DENIAL, REFUSAL,

OR REVOCATION

CHAPTER 2652. ESCROW OFFICERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2652.001. LICENSE AND BOND OR DEPOSIT REQUIRED. An individual may not act as an escrow officer unless the individual:

(1) holds a license issued by the department; and

(2) maintains a surety bond or deposit required under

Subchapter C. (V.T.I.C. Art. 9.41, Sec. A (part); New.)

Sec. 2652.002. EMPLOYMENT OF ESCROW OFFICER. (a) A title

1 insurance agent or direct operation may not employ an individual as
2 an escrow officer unless the individual holds a license and
3 maintains a surety bond or deposit as required by this chapter.

4 (b) A title insurance agent or direct operation may not
5 permit an individual to act as an escrow officer in this state
6 before the agent or direct operation has complied with Sections
7 2652.151 and 2652.152 with respect to the individual. (V.T.I.C.
8 Art. 9.41, Sec. A (part); Art. 9.42, Sec. 1(a) (part); New.)

9 Sec. 2652.003. ATTORNEY ACTING AS ESCROW OFFICER. (a)
10 Notwithstanding Section 2652.001, an attorney is not required to be
11 licensed as an escrow officer to perform the duties of an escrow
12 officer as defined by Section 2501.003.

13 (b) An attorney may hold a license to act as an escrow
14 officer. An employee of an attorney licensed as an escrow officer
15 also may hold a license to act as an escrow officer. An attorney
16 licensed as an escrow officer shall comply with the provisions of
17 this code that apply to escrow officers and trust funds as if the
18 attorney were a title insurance agent.

19 (c) Notwithstanding any other provision of this chapter, a
20 title insurance company or title insurance agent may not permit an
21 attorney to conduct the attorney's business in the name of the
22 company or agent unless the attorney and the attorney's bona fide
23 employees who close transactions are licensed escrow officers.
24 (V.T.I.C. Art. 9.41, Secs. B, C.)

25 Sec. 2652.004. TRUST FUND ACCOUNT DISBURSEMENTS. (a) An
26 escrow officer may not disburse funds from a trust fund account
27 until good funds related to the transaction have been received and

1 deposited in the account in amounts sufficient to fund any
2 disbursements from the transaction.

3 (b) An escrow officer is not liable for a violation of this
4 section if the violation:

5 (1) was not intentional; and

6 (2) resulted from a bona fide error despite the
7 maintenance of procedures reasonably adopted to avoid the error.

8 (c) The commissioner shall adopt rules and definitions to
9 implement this section. (V.T.I.C. Art. 9.39A, Secs. (a) (part),
10 (b), (c) (part).)

11 Sec. 2652.005. ESCROW ACCOUNT AUDIT. Each escrow account
12 used by a licensed escrow officer for closing a transaction is
13 subject to the audit requirements of Subchapter D, Chapter 2651.
14 (V.T.I.C. Art. 9.41, Sec. D.)

15 Sec. 2652.006. RECORD OF ESCROW OFFICERS. The department
16 shall maintain a record of the name and address of each escrow
17 officer licensed by the department in a manner that ensures that the
18 escrow officers employed by any title insurance agent or direct
19 operation in this state may be conveniently determined. (V.T.I.C.
20 Art. 9.42, Sec. 1(c).)

21 [Sections 2652.007-2652.050 reserved for expansion]

22 SUBCHAPTER B. LICENSE APPLICATION AND RENEWAL

23 Sec. 2652.051. LICENSE APPLICATION. (a) Before an initial
24 license is issued to an individual to act as an escrow officer in
25 this state for a title insurance agent or direct operation, the
26 title insurance agent or direct operation must file an application
27 for an escrow officer's license with the department on forms

1 provided by the department.

2 (b) The application must be:

3 (1) accompanied by a nonrefundable license fee; and

4 (2) signed and sworn to by the title insurance agent or
5 direct operation and by the proposed escrow officer.

6 (c) The completed application must state that:

7 (1) the proposed escrow officer is an individual who
8 is a bona fide resident of this state;

9 (2) the proposed escrow officer is an attorney or is a
10 bona fide employee of:

11 (A) an attorney licensed as an escrow officer; or

12 (B) a title insurance agent or direct operation;

13 (3) the proposed escrow officer has reasonable
14 experience or instruction in the field of title insurance; and

15 (4) the title insurance agent or direct operation does
16 not know of any fact or condition that disqualifies the proposed
17 escrow officer from receiving a license. (V.T.I.C. Art. 9.43,
18 Secs. A (part), B.)

19 Sec. 2652.052. LICENSE AND RENEWAL FEES. (a) The
20 department shall prescribe the license fee in an amount not to
21 exceed \$50.

22 (b) License fees, and renewal fees collected under Section
23 2652.152, shall be deposited to the credit of the Texas Department
24 of Insurance operating account to be used by the department to
25 enforce this chapter and any other law of this state that regulates
26 escrow officers for title insurance agents or direct operations.
27 (V.T.I.C. Art. 9.43, Sec. A (part).)

1 Sec. 2652.053. LICENSE ISSUANCE. The department shall
2 issue a license if the department determines, based on the
3 application and the department's investigation, that the
4 requirements of Section 2652.051 are satisfied. (V.T.I.C. Art.
5 9.43, Sec. C.)

6 Sec. 2652.054. DUPLICATE LICENSE. (a) The department
7 shall collect in advance a fee from a title insurance agent or
8 direct operation that requests a duplicate license.

9 (b) The department shall prescribe the fee in an amount not
10 to exceed \$20. (V.T.I.C. Art. 9.43, Sec. D.)

11 Sec. 2652.055. LICENSE TERM. Unless a system of staggered
12 license renewal is adopted under Section 4003.002, a license
13 expires on the second June 1 following the date of issuance.
14 (V.T.I.C. Art. 9.42, Sec. 1(b) (part).)

15 Sec. 2652.056. AUTOMATIC TERMINATION OF LICENSE. The
16 license of each escrow officer employed by a title insurance agent
17 or direct operation that surrenders its license or has its license
18 revoked by the department is automatically terminated without
19 notice. (V.T.I.C. Art. 9.42, Sec. 1(b) (part).)

20 Sec. 2652.057. LICENSE SURRENDER OR FORFEITURE. (a) An
21 escrow officer may voluntarily surrender the escrow officer's
22 license at any time by giving notice to the department.

23 (b) An escrow officer automatically forfeits the escrow
24 officer's license if the officer is not employed as an escrow
25 officer.

26 (c) A surrender or forfeiture of a license under this
27 section does not affect the culpability of the license holder for

1 conduct committed before the effective date of the surrender or
2 forfeiture. The department may institute a disciplinary proceeding
3 against the former license holder for conduct committed before the
4 effective date of the surrender or forfeiture. (V.T.I.C. Art.
5 9.44, Secs. 1, 6.)

6 Sec. 2652.058. CONTINUING EDUCATION. (a) To protect the
7 public and to preserve and improve the competence of license
8 holders, the department shall require as a condition of holding an
9 escrow officer license that the license holder enroll in and attend
10 or teach continuing education consisting of class instruction,
11 lectures, seminars, or other forms of education approved by the
12 department for escrow officers.

13 (b) The department shall prescribe the required number of
14 hours of continuing education, not to exceed 15 hours in each
15 two-year license period.

16 (c) Continuing education instruction must be designed to
17 refresh the license holder's understanding of:

18 (1) basic principles and coverages relating to title
19 insurance;

20 (2) recent and prospective changes in those principles
21 and coverages;

22 (3) applicable rules of the commissioner and laws;

23 (4) the proper conduct of the license holder's
24 business; and

25 (5) the duties and responsibilities of the license
26 holder.

27 (d) The department may permit a license holder to complete

1 an equivalent course of study and instruction by mail if, because of
2 the remote location of the license holder's residence or business,
3 the license holder is unable to attend educational sessions with
4 reasonable convenience.

5 (e) On written request by the license holder, the department
6 may extend the time for the license holder to comply with the
7 requirements of this section or may exempt the license holder from
8 all or part of the requirements for a license period if the
9 department determines that the license holder is unable to comply
10 with the requirements because of illness, medical disability, or
11 another extenuating circumstance beyond the control of the license
12 holder. The commissioner shall prescribe the criteria for an
13 extension or exemption by rule.

14 (f) The commissioner shall adopt rules to administer this
15 section. (V.T.I.C. Art. 9.58, Secs. A (part), B, C, D, E.)

16 [Sections 2652.059-2652.100 reserved for expansion]

17 SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

18 Sec. 2652.101. BOND REQUIRED. (a) A title insurance agent
19 or direct operation shall obtain, at its own expense, a bond for its
20 escrow officers payable to the department. The bond shall obligate
21 the principal and surety to pay for any pecuniary loss sustained by
22 the title insurance agent or direct operation through an act of
23 fraud, dishonesty, forgery, theft, embezzlement, or wilful
24 misapplication by an escrow officer, either directly and alone or
25 in conspiracy with another person.

26 (b) The bond must be:

27 (1) of a type approved by the department; and

1 (2) issued by a surety licensed by the department to do
2 business in this state. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

3 Sec. 2652.102. ALTERNATIVE TO BOND. (a) Instead of the
4 bond required by Section 2652.101, a title insurance agent or
5 direct operation may deposit with the department:

6 (1) cash;

7 (2) irrevocable letters of credit issued by a
8 financial institution insured by an agency of the United States; or

9 (3) securities approved by the department.

10 (b) The cash, letters of credit, or securities deposited
11 under this section are subject to the conditions required for a bond
12 under Section 2652.101. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

13 Sec. 2652.103. AMOUNT OF BOND OR DEPOSIT. The amount of the
14 bond or deposit required under this subchapter is determined by
15 multiplying the number of escrow officers employed by the title
16 insurance agent or direct operation by \$5,000, except that the
17 maximum amount of the bond or deposit required under this
18 subchapter is \$50,000. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

19 Sec. 2652.104. EXAMINATION OF LOSS COVERED BY BOND OR
20 DEPOSIT. (a) At any time it appears that a loss covered by a bond
21 or deposit has occurred, the department may require the escrow
22 officer to appear in Travis County, with records the department
23 determines to be proper, for an examination.

24 (b) The department shall specify a date for the examination
25 that is not earlier than the 10th day or later than the 15th day
26 after the date of service of notice of the requirement to appear.
27 Copies of the notice shall be sent to any title insurance agent or

1 direct operation concerned.

2 (c) If after the examination the department determines that
3 a loss covered by the bond or deposit has occurred, the department
4 shall immediately notify the appropriate title insurance agent or
5 direct operation and the surety on the bond, if applicable, and
6 prepare a written statement of the facts of the loss and deliver the
7 statement to the attorney general. (V.T.I.C. Art. 9.45, Sec. (b)
8 (part).)

9 Sec. 2652.105. INVESTIGATION BY ATTORNEY GENERAL. (a) On
10 receipt of a written statement under Section 2652.104, the attorney
11 general shall investigate the charges and, on determining that a
12 loss covered by the bond or deposit has occurred, shall enforce the
13 liability by collecting against the deposited cash or securities or
14 by filing suit on the bond.

15 (b) A suit brought under this section shall be filed in the
16 name of the department in Travis County for the benefit of all
17 parties who have suffered any loss covered by the bond or deposit.
18 (V.T.I.C. Art. 9.45, Sec. (b) (part).)

19 [Sections 2652.106-2652.150 reserved for expansion]

20 SUBCHAPTER D. DUTIES OF TITLE INSURANCE AGENTS AND
21 DIRECT OPERATIONS REGARDING ESCROW OFFICERS

22 Sec. 2652.151. LIST OF ESCROW OFFICERS. (a) A title
23 insurance agent or direct operation shall certify to the
24 department, not later than the expiration date of the title
25 insurance agent's or direct operation's license, the name and
26 address of each individual employed by the title insurance agent or
27 direct operation to serve as an escrow officer in this state.

1 (b) The certification required by this section must be on a
2 form provided by the department. (V.T.I.C. Art. 9.42, Sec. 1(a)
3 (part).)

4 Sec. 2652.152. RENEWAL. A title insurance agent or direct
5 operation shall apply for renewal and pay a nonrefundable license
6 renewal fee prescribed by the department in an amount not to exceed
7 \$50 for each escrow officer listed by the title insurance agent or
8 direct operation under Section 2652.151. (V.T.I.C. Art. 9.42, Sec.
9 1(a) (part).)

10 Sec. 2652.153. NOTICE OF TERMINATION. A title insurance
11 agent or direct operation that terminates the employment of a
12 licensed escrow officer shall:

13 (1) immediately notify the department in writing of
14 the termination and request cancellation of the license; and

15 (2) notify the escrow officer of the action by the
16 title insurance agent or direct operation. (V.T.I.C. Art. 9.42,
17 Sec. 1(a) (part).)

18 [Sections 2652.154-2652.200 reserved for expansion]

19 SUBCHAPTER E. LICENSE DENIAL AND DISCIPLINARY ACTION

20 Sec. 2652.201. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
21 ACTION. The department may deny an application for a license or
22 discipline an escrow officer under Sections 4005.102, 4005.103, and
23 4005.104 if the department determines that the applicant or license
24 holder has:

25 (1) wilfully violated this title;

26 (2) intentionally made a material misstatement in the
27 license application;

1 (3) obtained or attempted to obtain the license by
2 fraud or misrepresentation;

3 (4) misappropriated or converted to the escrow
4 officer's own use or illegally withheld money belonging to a title
5 insurance agent, direct operation, or another person;

6 (5) been guilty of fraudulent or dishonest practices;

7 (6) materially misrepresented the terms and
8 conditions of a title insurance policy or contract; or

9 (7) failed to complete all educational requirements.
10 (V.T.I.C. Art. 9.44, Sec. 2.)

11 Sec. 2652.202. LICENSE APPLICATION AFTER DENIAL, REFUSAL,
12 OR REVOCATION. (a) An applicant whose license application has been
13 denied or refused or a license holder whose license has been revoked
14 under this subchapter may not file another application for a
15 license as an escrow officer before the first anniversary of:

16 (1) the effective date of the denial, refusal, or
17 revocation; or

18 (2) the date of a final court order affirming the
19 denial, refusal, or revocation if judicial review is sought.

20 (b) A license application filed after the time required by
21 this section may be denied by the department unless the applicant
22 shows good cause why the denial, refusal, or revocation should not
23 be a bar to the issuance of a license. (V.T.I.C. Art. 9.44, Sec. 4.)

24 [Chapters 2653-2700 reserved for expansion]

25 SUBTITLE E. THE BUSINESS OF TITLE INSURANCE

26 CHAPTER 2701. GENERAL PROVISIONS

27 Sec. 2701.001. ABSTRACT OF TITLE DISTINGUISHED; PROHIBITION

ON REGULATION OF ABSTRACT OF TITLE

Sec. 2701.002. CONSTRUCTION OF CHAPTER 39, BUSINESS
& COMMERCE CODE

CHAPTER 2701. GENERAL PROVISIONS

Sec. 2701.001. ABSTRACT OF TITLE DISTINGUISHED;
PROHIBITION ON REGULATION OF ABSTRACT OF TITLE. (a) In this
section, "commitment for title insurance" means a title insurance
form under which a title insurance company offers to issue a title
insurance policy subject to stated exceptions, requirements, and
terms. The term includes a mortgagee title policy binder on an
interim construction loan.

(b) A commitment for title insurance constitutes a
statement of the terms and conditions on which a title insurance
company is willing to issue its policy. A title insurance policy or
other title insurance form constitutes a statement of the terms and
conditions of the indemnity under the policy or form.

(c) An abstract of title prepared from an abstract plant for
a chain of title to real property described in the abstract of title
is not title insurance, a commitment for title insurance, or any
other title insurance form. A commitment for title insurance,
title insurance policy, or other title insurance form is not an
abstract of title.

(d) The commissioner may not adopt rules relating to
abstracts of title. (V.T.I.C. Art. 9.07B.)

Sec. 2701.002. CONSTRUCTION OF CHAPTER 39, BUSINESS &
COMMERCE CODE. Chapter 39, Business & Commerce Code, is a consumer
protection law when construed in connection with a title insurance

1 policy issued in this state. (V.T.I.C. Art. 9.50.)

2 CHAPTER 2702. CLOSING AND SETTLEMENT

3 SUBCHAPTER A. INSURED CLOSING AND SETTLEMENT LETTERS

4 Sec. 2702.001. INSURED CLOSING AND SETTLEMENT LETTER:

5 LOANS

6 Sec. 2702.002. INSURED CLOSING AND SETTLEMENT LETTER:

7 CERTAIN BUYERS OR SELLERS

8 Sec. 2702.003. EFFECT OF FAILURE TO ISSUE INSURED

9 CLOSING AND SETTLEMENT LETTER

10 [Sections 2702.004-2702.050 reserved for expansion]

11 SUBCHAPTER B. UNIFORM CLOSING AND SETTLEMENT STATEMENTS

12 Sec. 2702.051. APPLICABILITY

13 Sec. 2702.052. DUTY TO PRESCRIBE UNIFORM CLOSING AND

14 SETTLEMENT STATEMENT FORMS

15 Sec. 2702.053. CONTENT OF CLOSING AND SETTLEMENT STATEMENT

16 Sec. 2702.054. USE OF ALTERNATE SETTLEMENT STATEMENT FORM

17 PERMITTED

18 [Sections 2702.055-2702.100 reserved for expansion]

19 SUBCHAPTER C. ADVANCE DISCLOSURE OF CLOSING AND SETTLEMENT

20 COSTS IN TRANSACTIONS INVOLVING RESIDENTIAL REAL PROPERTY

21 Sec. 2702.101. APPLICABILITY

22 Sec. 2702.102. DUTY TO PROVIDE ADVANCE DISCLOSURE OF CLOSING

23 AND SETTLEMENT COSTS

24 Sec. 2702.103. TITLE INSURANCE COMPANY OR TITLE INSURANCE

25 AGENT NOT SUBJECT TO REQUIREMENTS

26 APPLICABLE TO LENDERS

27 CHAPTER 2702. CLOSING AND SETTLEMENT

SUBCHAPTER A. INSURED CLOSING AND SETTLEMENT LETTERS

Sec. 2702.001. INSURED CLOSING AND SETTLEMENT LETTER:
LOANS. (a) On request, a title insurance company may issue insured
closing and settlement letters in connection with the closing and
settlement by a title insurance agent or direct operation of loans
relating to real property located in this state.

(b) Insured closing and settlement letters must be issued in
the form prescribed by the commissioner.

(c) A title insurance company may not impose a charge for
issuing insured closing and settlement letters under this section.
(V.T.I.C. Art. 9.49, Sec. (a) (part).)

Sec. 2702.002. INSURED CLOSING AND SETTLEMENT LETTER:
CERTAIN BUYERS OR SELLERS. (a) On written request, a title
insurance company may issue to the buyer or seller of real property
located in this state, the sales price of which exceeds the maximum
covered claim specified by Chapter 2602, an insured closing and
settlement letter in connection with the closing and settlement of
the transaction by a title insurance agent or direct operation.
Only the title insurance company that is to issue an owner title
insurance policy in connection with the transaction may issue the
insured closing and settlement letter.

(b) An insured closing and settlement letter must be issued:
(1) at or before closing; and
(2) in the form and manner prescribed by the
commissioner.

(c) The commissioner may adopt a charge for the issuance of
an insured closing and settlement letter under this section and

1 prescribe the form and manner in which the charge must be made.
2 (V.T.I.C. Art. 9.49, Sec. (b) (part).)

3 Sec. 2702.003. EFFECT OF FAILURE TO ISSUE INSURED CLOSING
4 AND SETTLEMENT LETTER. The failure of a title insurance company to
5 issue an insured closing and settlement letter does not affect the
6 company's liability under an issued title insurance policy.
7 (V.T.I.C. Art. 9.49, Secs. (a) (part), (b) (part).)

8 [Sections 2702.004-2702.050 reserved for expansion]

9 SUBCHAPTER B. UNIFORM CLOSING AND SETTLEMENT STATEMENTS

10 Sec. 2702.051. APPLICABILITY. This subchapter does not
11 apply to the closing or settlement of:

12 (1) a residential real property transaction regulated
13 by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No.
14 93-533); or

15 (2) a real property transaction if the closing or
16 settlement is not actually handled by:

17 (A) a title insurance company, a title insurance
18 agent, or an attorney for a title insurance company or title
19 insurance agent; or

20 (B) a representative of a title insurance
21 company, a title insurance agent, or an attorney for a title
22 insurance company or title insurance agent. (V.T.I.C. Art. 9.53
23 (part).)

24 Sec. 2702.052. DUTY TO PRESCRIBE UNIFORM CLOSING AND
25 SETTLEMENT STATEMENT FORMS. (a) The department, after notice and
26 hearing, shall prescribe uniform closing and settlement statement
27 forms to be used in connection with the closing and settlement of a

1 transaction involving:

2 (1) the conveyance or mortgage of real property; and

3 (2) the issuance of a title insurance policy by a title
4 insurance company or title insurance agent.

5 (b) The department may prescribe separate forms under this
6 section for transactions involving improved residential real
7 property and for all other real property transactions.

8 (c) The department shall design the forms under this section
9 to enable each party to the transaction to be provided with a dual
10 or separate form identifying only the charges made to that party.
11 (V.T.I.C. Art. 9.53 (part).)

12 Sec. 2702.053. CONTENT OF CLOSING AND SETTLEMENT STATEMENT.

13 (a) Each closing and settlement statement provided to a party to a
14 transaction described by Section 2702.052(a) must state the name of
15 any person receiving any amount from that party.

16 (b) Notwithstanding Subsection (a), the title insurance
17 company or title insurance agent is required to include in the
18 closing and settlement statement only those items of disbursement
19 that are actually disbursed by the company or agent.

20 (c) If an attorney, other than a full-time employee of the
21 title insurance company or title insurance agent, examines a title
22 or provides any closing or settlement services, the closing and
23 settlement statement must include:

24 (1) the amount of the fee for the services, shown as
25 included in the premium; and

26 (2) the name of the attorney or, if applicable, the
27 name of the firm to which the fee was paid.

1 (d) The closing and settlement statement must conspicuously
2 and clearly itemize the charges imposed on the party in connection
3 with the closing and settlement.

4 (e) If a charge for title insurance is made to the party, the
5 closing and settlement statement must state whether the title
6 insurance premium included in the charge covers the mortgagee's
7 interest in the real property, the borrower's interest, or both.
8 (V.T.I.C. Art. 9.53 (part).)

9 Sec. 2702.054. USE OF ALTERNATE SETTLEMENT STATEMENT FORM
10 PERMITTED. A title insurance company or title insurance agent may
11 use the uniform settlement statement form prepared under the Real
12 Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533)
13 instead of the uniform closing and settlement statement form
14 prescribed by the department under this subchapter. (V.T.I.C. Art.
15 9.53 (part).)

16 [Sections 2702.055-2702.100 reserved for expansion]

17 SUBCHAPTER C. ADVANCE DISCLOSURE OF CLOSING AND SETTLEMENT
18 COSTS IN TRANSACTIONS INVOLVING RESIDENTIAL REAL PROPERTY

19 Sec. 2702.101. APPLICABILITY. This subchapter does not
20 apply to the closing or settlement of a real property transaction if
21 the closing or settlement is not actually handled by:

22 (1) a title insurance company, a title insurance
23 agent, or an attorney for a title insurance company or title
24 insurance agent; or

25 (2) a representative of a title insurance company, a
26 title insurance agent, or an attorney for a title insurance company
27 or title insurance agent. (V.T.I.C. Art. 9.54 (part).)

1 Sec. 2702.102. DUTY TO PROVIDE ADVANCE DISCLOSURE OF
2 CLOSING AND SETTLEMENT COSTS. (a) Except as provided by Subsection
3 (c), on the written request of the buyer, seller, or borrower before
4 the closing and settlement of a transaction involving improved
5 residential real property, a title insurance company or title
6 insurance agent shall, in connection with the issuance of any kind
7 of title insurance policy guaranteeing a lien on or the title to the
8 property, provide to the requesting party an itemized disclosure of
9 each charge to be made to that party that arises in connection with
10 the closing and settlement.

11 (b) The itemized disclosure must be provided on a closing
12 and settlement statement form prescribed or permitted under
13 Subchapter B.

14 (c) The title insurance company or title insurance agent is
15 required to provide the itemized disclosure only to the extent that
16 information is available concerning each charge to be made to the
17 party. If information concerning a charge is not available, the
18 title insurance company or title insurance agent shall:

19 (1) make a notation that the charge is to be made but
20 that the information is not available or that the amount shown is an
21 estimate of the charge; and

22 (2) advise the party in writing as to the identity of
23 the person or organization responsible for the charge. (V.T.I.C.
24 Art. 9.54 (part).)

25 Sec. 2702.103. TITLE INSURANCE COMPANY OR TITLE INSURANCE
26 AGENT NOT SUBJECT TO REQUIREMENTS APPLICABLE TO LENDERS. (a)
27 Notwithstanding Section 2702.102, a title insurance company or

1 title insurance agent is not required to disclose a cost or charge
2 that a lender is required by law to disclose to a party.

3 (b) Section 2702.102 does not impose on a title insurance
4 company or title insurance agent any obligation imposed on a lender
5 by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No.
6 93-533). (V.T.I.C. Art. 9.54 (part).)

7 CHAPTER 2703. POLICY FORMS AND PREMIUM RATES

8 SUBCHAPTER A. GENERAL PROVISIONS

9 Sec. 2703.001. COMPLIANCE WITH TITLE AND RULES

10 Sec. 2703.002. USE OF FORMS IN GENERAL

11 Sec. 2703.003. PAYMENT OF PREMIUMS

12 [Sections 2703.004-2703.050 reserved for expansion]

13 SUBCHAPTER B. POLICY PROVISIONS

14 Sec. 2703.051. CERTAIN PROVISIONS REQUIRED

15 Sec. 2703.052. DUTY OF TITLE INSURANCE COMPANY

16 Sec. 2703.053. ESTABLISHMENT OF STANDARDS AND

17 SCHEDULES

18 Sec. 2703.054. AUTHORITY OF COMMISSIONER IN IMPLEMENTING

19 SUBCHAPTER

20 [Sections 2703.055-2703.100 reserved for expansion]

21 SUBCHAPTER C. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

22 Sec. 2703.101. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

23 [Sections 2703.102-2703.150 reserved for expansion]

24 SUBCHAPTER D. FIXING AND PROMULGATING PREMIUM RATES

25 Sec. 2703.151. FIXING AND PROMULGATING PREMIUM RATES

26 Sec. 2703.152. FACTORS CONSIDERED IN FIXING PREMIUM

27 RATES

1 Sec. 2703.153. COLLECTION OF DATA FOR FIXING PREMIUM

2 RATES

3 [Sections 2703.154-2703.200 reserved for expansion]

4 SUBCHAPTER E. PROCEDURES REGARDING PREMIUM RATES,

5 POLICY FORMS, AND OTHER RELATED MATTERS

6 Sec. 2703.201. HEARING REQUIRED FOR FIXING PREMIUM

7 RATE

8 Sec. 2703.202. HEARING REQUIRED FOR CHANGE IN PREMIUM RATE

9 Sec. 2703.203. BIENNIAL HEARING

10 Sec. 2703.204. ADMISSION AS PARTY TO BIENNIAL HEARING

11 Sec. 2703.205. PHASES OF BIENNIAL HEARING

12 Sec. 2703.206. COMMISSIONER AUTHORITY TO HOLD HEARINGS

13 AS NECESSARY

14 Sec. 2703.207. NOTICE OF CERTAIN HEARINGS

15 Sec. 2703.208. ADDITIONS OR AMENDMENTS TO MANUAL

16 CHAPTER 2703. POLICY FORMS AND PREMIUM RATES

17 SUBCHAPTER A. GENERAL PROVISIONS

18 Sec. 2703.001. COMPLIANCE WITH TITLE AND RULES. (a) This
19 section applies to a corporation organized under this title, a
20 foreign corporation, and, to the extent that the corporation is
21 engaged in the business of title insurance, a corporation organized
22 under another law, including:

23 (1) Subdivision 57, Article 1302, Revised Statutes,
24 before repeal of that statute; and

25 (2) Chapter 861.

26 (b) A corporation operates in this state under the control
27 and supervision of the commissioner and under uniform rules adopted

1 by the commissioner relating to:

- 2 (1) forms of policies and underwriting contracts;
- 3 (2) premiums for those policies and contracts; and
- 4 (3) underwriting standards and practices.

5 (c) With respect to real property located in this state, a
6 corporation may not issue any kind of title insurance coverage, any
7 kind of guarantee, or reinsurance of a risk assumed under a title
8 insurance policy, except as provided by Section 2551.305(a), unless
9 the corporation is authorized to engage in the business of title
10 insurance under this title and otherwise complies with this title.
11 In engaging in the business of title insurance with respect to real
12 property located in this state, the corporation shall comply with
13 this title and rules described by Subsection (b), including when:

- 14 (1) issuing any kind of title insurance policy or an
15 underwriting contract;
- 16 (2) reinsuring any portion of a risk assumed under a
17 title insurance policy; and
- 18 (3) deleting a title insurance policy exclusion.

19 (d) Title insurance coverage, reinsurance, or a guarantee
20 issued in violation of Subsection (c) is invalid. (V.T.I.C. Art.
21 9.07, Sec. (a) (part).)

22 Sec. 2703.002. USE OF FORMS IN GENERAL. A title insurance
23 company or title insurance agent may not use a form required under
24 this title to be prescribed or approved until the commissioner has
25 prescribed or approved the form. (V.T.I.C. Art. 9.07, Sec. (a)
26 (part).)

27 Sec. 2703.003. PAYMENT OF PREMIUMS. The premium for a title

1 insurance policy or for another form prescribed or approved by the
2 commissioner shall be paid in the due and ordinary course of
3 business. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

4 [Sections 2703.004-2703.050 reserved for expansion]

5 SUBCHAPTER B. POLICY PROVISIONS

6 Sec. 2703.051. CERTAIN PROVISIONS REQUIRED. A title
7 insurance policy delivered or issued for delivery in this state to
8 insure an owner of real property must include certain provisions,
9 the form and content of which shall be prescribed by the
10 commissioner, in accordance with this subchapter. (V.T.I.C. Art.
11 9.57, Sec. (a).)

12 Sec. 2703.052. DUTY OF TITLE INSURANCE COMPANY. (a) On a
13 report to a title insurance company made by an insured after a title
14 insurance policy has been issued that a lien, encumbrance, or title
15 defect exists that is not excepted under the policy or otherwise
16 excluded from coverage, the company shall promptly investigate to
17 determine whether the lien or encumbrance is valid and not barred by
18 statute or other law.

19 (b) A title insurance company that concludes that a valid
20 lien or encumbrance that is not barred by statute or other law
21 exists or that a title defect exists shall:

22 (1) institute all necessary legal proceedings to clear
23 the title to the property;

24 (2) indemnify the insured according to the terms of
25 the policy;

26 (3) reinsure at current value the title to the
27 property without making exception to the lien, encumbrance, or

1 defect or indemnify another insurer for reinsuring the title
2 without making exception to the lien, encumbrance, or defect;

3 (4) secure a release of the lien, encumbrance, or
4 defect; or

5 (5) take a combination of the actions described by
6 this subsection. (V.T.I.C. Art. 9.57, Sec. (b).)

7 Sec. 2703.053. ESTABLISHMENT OF STANDARDS AND SCHEDULES.
8 The commissioner by rule shall establish standards and time
9 schedules for implementing and handling claims by title insurance
10 companies in accordance with this subchapter. (V.T.I.C. Art. 9.57,
11 Sec. (d).)

12 Sec. 2703.054. AUTHORITY OF COMMISSIONER IN IMPLEMENTING
13 SUBCHAPTER. (a) The commissioner may adopt, by amendment to an
14 owner title insurance policy or by separate endorsement to an owner
15 title insurance policy, language to implement this subchapter in a
16 manner consistent with the terms, provisions, conditions, and
17 stipulations of the policy or the exceptions to coverage contained
18 in the schedules to the policy.

19 (b) This subchapter does not prohibit the commissioner from
20 adopting for use in this state one or more policies in a simplified,
21 generally more understandable, and usable form. (V.T.I.C. Art.
22 9.57, Sec. (c).)

23 [Sections 2703.055-2703.100 reserved for expansion]

24 SUBCHAPTER C. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

25 Sec. 2703.101. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY.

26 (a) The commissioner shall prescribe an owner title insurance
27 policy form to be issued in connection with a transaction involving

1 residential real property in this state.

2 (b) A title insurance company or title insurance agent shall
3 use the form prescribed by the commissioner in issuing to an
4 individual an owner title insurance policy relating to residential
5 real property in this state.

6 (c) Unless authorized by rule adopted by the commissioner,
7 an insurer may not enter into a contract or other agreement
8 concerning an individual title insurance policy if the contract or
9 other agreement is not expressed in the policy. A contract or
10 agreement prohibited by this subsection is void.

11 (d) An endorsement prescribed by the commissioner may be
12 attached to the title insurance policy form as authorized by rule
13 adopted by the commissioner.

14 (e) The commissioner may not prescribe an owner title
15 insurance policy form for residential real property or an
16 endorsement to the policy if the policy form or endorsement is not
17 written in plain language. For purposes of this subsection, a
18 policy form or endorsement is written in plain language if it
19 achieves the minimum score established by the commissioner on the
20 Flesch reading ease test or an equivalent test selected by the
21 commissioner or, at the commissioner's option, if it conforms to
22 the language requirements in a National Association of Insurance
23 Commissioners model act relating to plain language. This
24 subsection does not apply to policy language required by state or
25 federal law.

26 (f) For an owner title insurance policy on residential real
27 property that is issued to an individual, the commissioner may

1 adopt coverages that insure against ad valorem taxes, including
2 penalties and interest, to be paid with respect to the property for
3 a previous tax year:

4 (1) that are delinquent on the effective date of the
5 policy because of sale, diversion, or change of use, unless
6 excluded because the insured has actual knowledge of the delinquent
7 taxes; or

8 (2) that result from an exemption granted to a
9 previous owner of the property under Section 11.13, Tax Code, or
10 from an improvement not assessed for a previous tax year, unless
11 excluded because the insured has actual knowledge of the taxes.
12 (V.T.I.C. Art. 9.07A.)

13 [Sections 2703.102-2703.150 reserved for expansion]

14 SUBCHAPTER D. FIXING AND PROMULGATING PREMIUM RATES

15 Sec. 2703.151. FIXING AND PROMULGATING PREMIUM RATES. (a)
16 Except as provided by Subsection (b), the commissioner shall fix
17 and promulgate the premium rates to be charged by a title insurance
18 company or by a title insurance agent for title insurance policies
19 or for other forms prescribed or approved by the commissioner.

20 (b) The commissioner may not fix or promulgate the premium
21 rates for reinsurance between title insurance companies. Title
22 insurance companies may establish the premium rates in amounts to
23 which the companies agree.

24 (c) Except for a premium charged for reinsurance, a premium
25 may not be charged for a title insurance policy or for another
26 prescribed or approved form at a rate different than the rate fixed
27 and promulgated by the commissioner. (V.T.I.C. Art. 9.07, Sec. (b))

(part).)

Sec. 2703.152. FACTORS CONSIDERED IN FIXING PREMIUM RATES.

(a) In fixing premium rates, the commissioner shall consider all relevant income and expenses of title insurance companies and title insurance agents attributable to engaging in the business of title insurance in this state.

(b) The premium rates fixed by the commissioner must be:

(1) reasonable as to the public; and

(2) nonconfiscatory as to title insurance companies and title insurance agents. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

Sec. 2703.153. COLLECTION OF DATA FOR FIXING PREMIUM RATES.

(a) Each title insurance company and title insurance agent engaged in the business of title insurance in this state shall submit to the department, as required by the department to collect data to use to fix premium rates, all information relating to:

(1) loss experience;

(2) expense of operation; and

(3) other material matters.

(b) The information must be submitted in the form prescribed by the department. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

[Sections 2703.154-2703.200 reserved for expansion]

SUBCHAPTER E. PROCEDURES REGARDING PREMIUM RATES,

POLICY FORMS, AND OTHER RELATED MATTERS

Sec. 2703.201. HEARING REQUIRED FOR FIXING PREMIUM RATE.

Before a premium rate may be fixed and a premium charged, the department must provide reasonable notice and a hearing must be afforded to title insurance companies, title insurance agents, and

1 the public. (V.T.I.C. Art. 9.07, Sec. (a) (part).)

2 Sec. 2703.202. HEARING REQUIRED FOR CHANGE IN PREMIUM RATE.

3 (a) A premium rate previously fixed by the commissioner may not be
4 changed until after the commissioner holds a public hearing.

5 (b) At the request of a title insurance company or the
6 office of public insurance counsel, the commissioner shall order a
7 public hearing to consider changing a premium rate. (V.T.I.C. Art.
8 9.07, Sec. (d) (part).)

9 Sec. 2703.203. BIENNIAL HEARING. The commissioner shall
10 hold a biennial public hearing not earlier than July 1 of each
11 even-numbered year to consider adoption of premium rates and other
12 matters relating to regulating the business of title insurance that
13 an association, title insurance company, title insurance agent, or
14 member of the public requests to be considered or that the
15 commissioner determines necessary to consider. (V.T.I.C. Art.
16 9.07, Sec. (c) (part).)

17 Sec. 2703.204. ADMISSION AS PARTY TO BIENNIAL HEARING. An
18 individual or association or other entity recommending adoption of
19 a premium rate or another matter relating to regulating the
20 business of title insurance shall be admitted as a party to the
21 biennial hearing. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

22 Sec. 2703.205. PHASES OF BIENNIAL HEARING. (a) The
23 biennial hearing consists of:

24 (1) a rulemaking phase to consider rules, forms,
25 endorsements, and related matters that do not have rate
26 implications; and

27 (2) a ratemaking phase to consider fixing of premium

1 rates and other matters that have rate implications.

2 (b) The commissioner shall certify which matters have rate
3 implications to be considered in the ratemaking phase of the
4 hearing.

5 (c) Except as provided by Subsection (d), the commissioner
6 shall conduct both phases of the hearing.

7 (d) At the direction of the commissioner or at the written
8 request of a person seeking admission as a party to the ratemaking
9 phase of the hearing, the State Office of Administrative Hearings
10 shall conduct the ratemaking phase of the hearing in accordance
11 with Chapter 40. A request under this subsection must be made at
12 the time a person seeks to be admitted as a party to the hearing but
13 may not be made later than the 10th day after the date notice of the
14 hearing is provided under Section 2703.207.

15 (e) The ratemaking phase of the hearing shall be conducted
16 as a contested case in accordance with Chapter 2001, Government
17 Code.

18 (f) A party's presentation of relevant, admissible oral
19 testimony may not be limited.

20 (g) Each matter in each phase of the hearing shall be
21 considered by the commissioner and decisions on the matters made in
22 an open meeting. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

23 Sec. 2703.206. COMMISSIONER AUTHORITY TO HOLD HEARINGS AS
24 NECESSARY. At any time, the commissioner may order a public hearing
25 to consider adoption of premium rates and other matters relating to
26 regulating the business of title insurance as the commissioner
27 determines necessary or proper. (V.T.I.C. Art. 9.07, Sec. (e))

(part).)

Sec. 2703.207. NOTICE OF CERTAIN HEARINGS. Not later than the 60th day before the date of a hearing under Section 2703.202, 2703.203, or 2703.206, notice of the hearing and of each item to be considered at the hearing shall be:

(1) sent directly to all title insurance companies and title insurance agents; and

(2) provided to the public in a manner that gives fair notice concerning the hearing. (V.T.I.C. Art. 9.07, Secs. (c) (part), (d) (part), (e) (part).)

Sec. 2703.208. ADDITIONS OR AMENDMENTS TO MANUAL. (a) An addition or amendment to the Basic Manual of Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas may be proposed and adopted by reference by publishing notice of the proposal or adoption by reference in the Texas Register.

(b) Notice under this section must include:

(1) a brief summary of the substance of the matter to be added or amended; and

(2) a statement that the full text of the matter is available for review in the office of the chief clerk of the department. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT;

DETERMINATION OF INSURABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2704.001. ISSUANCE OF POLICY OR CONTRACT

Sec. 2704.002. DIRECT ISSUANCE OF POLICY OR CONTRACT

Sec. 2704.003. COPY OF POLICY OR CONTRACT TO AGENT OR DIRECT

OPERATION

Sec. 2704.004. EXCEPTIONS TO APPLICABILITY OF CHAPTER

[Sections 2704.005-2704.050 reserved for expansion]

SUBCHAPTER B. ISSUANCE OF OWNER AND MORTGAGEE POLICIES FOR
RESIDENTIAL REAL PROPERTY

Sec. 2704.051. ISSUANCE OF OWNER POLICY REQUIRED IN
CONNECTION WITH ISSUANCE OF MORTGAGEE
POLICY

Sec. 2704.052. REJECTION OF ISSUANCE OF OWNER POLICY

[Sections 2704.053-2704.100 reserved for expansion]

SUBCHAPTER C. TITLE INSURANCE COVERING AREAS AND BOUNDARIES

Sec. 2704.101. DEFINITION

Sec. 2704.102. RULES AUTHORIZING ACCEPTANCE OF EXISTING
SURVEY

Sec. 2704.103. CERTAIN DISCRIMINATION PROHIBITED

Sec. 2704.104. INDEMNITY PROHIBITED

CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT;
DETERMINATION OF INSURABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2704.001. ISSUANCE OF POLICY OR CONTRACT. A title
insurance policy or contract may not be written unless:

(1) Sections 2502.053, 2502.054, and 2502.055 have
been complied with;

(2) the policy or contract is based on an examination
of title made from title evidence prepared from an abstract plant
owned, or leased and operated by a title insurance agent or direct
operation for the county in which the real property is located,

1 except as provided by Section 2704.002;

2 (3) insurability of title has been determined in
3 accordance with sound title underwriting practices; and

4 (4) evidence thereof is preserved and retained in the
5 files of the title insurance company, title insurance agent, or
6 direct operation for a period of not less than 15 years after the
7 date of issuance of the policy or contract. (V.T.I.C. Art. 9.34
8 (part).)

9 Sec. 2704.002. DIRECT ISSUANCE OF POLICY OR CONTRACT. A
10 title insurance company may directly issue a title insurance policy
11 or contract based on the best title evidence available if:

12 (1) a title insurance agent or direct operation does
13 not exist for the county in which the real property is located; or

14 (2) each title insurance agent and direct operation
15 for that county refuses to provide title evidence:

16 (A) in a reasonable period as determined by the
17 department; and

18 (B) in compliance with Section 2502.053(1).
19 (V.T.I.C. Art. 9.34 (part).)

20 Sec. 2704.003. COPY OF POLICY OR CONTRACT TO AGENT OR DIRECT
21 OPERATION. In a reasonable period as determined by the department,
22 a copy of each title insurance policy or contract issued in a real
23 property transaction shall be provided to each title insurance
24 agent or direct operation providing the title evidence on which the
25 policy or contract is issued. (V.T.I.C. Art. 9.34 (part).)

26 Sec. 2704.004. EXCEPTIONS TO APPLICABILITY OF CHAPTER.
27 This chapter does not apply to a company that:

1 (1) does not assume primary liability in a reinsurance
2 contract; or

3 (2) acts as coinsurer, if at least one of the other
4 coinsurers has complied with this chapter. (V.T.I.C. Art. 9.34
5 (part).)

6 [Sections 2704.005-2704.050 reserved for expansion]

7 SUBCHAPTER B. ISSUANCE OF OWNER AND MORTGAGEE POLICIES FOR
8 RESIDENTIAL REAL PROPERTY

9 Sec. 2704.051. ISSUANCE OF OWNER POLICY REQUIRED IN
10 CONNECTION WITH ISSUANCE OF MORTGAGEE POLICY. (a) In this section,
11 "mortgagee title insurance policy" means a mortgagee policy of
12 title insurance or another agreement or the equivalent that
13 constitutes the business of title insurance.

14 (b) Except as provided by Section 2704.052, a title
15 insurance company or title insurance agent that issues a mortgagee
16 title insurance policy in connection with a lien on improved
17 residential real property in this state that is sold shall also
18 issue an owner title insurance policy to the owner of the property.

19 (c) The title insurance company or title insurance agent
20 issuing the owner title insurance policy shall charge the required
21 premium promulgated by the commissioner. (V.T.I.C. Art. 9.55
22 (part).)

23 Sec. 2704.052. REJECTION OF ISSUANCE OF OWNER POLICY. At or
24 before closing and settlement, the person acquiring title may
25 reject the issuance of the owner title insurance policy required
26 under Section 2704.051 by executing a written and acknowledged
27 rejection in the form prescribed, after notice and hearing, by the

1 commissioner. (V.T.I.C. Art. 9.55 (part).)

2 [Sections 2704.053-2704.100 reserved for expansion]

3 SUBCHAPTER C. TITLE INSURANCE COVERING AREAS AND BOUNDARIES

4 Sec. 2704.101. DEFINITION. In this subchapter, "area and
5 boundary coverage" means title insurance coverage relating to
6 discrepancies, conflicts, or shortages in area or boundary lines,
7 or any encroachments or protrusions, or any overlapping of
8 improvements. (V.T.I.C. Art. 9.07C, Sec. (a).)

9 Sec. 2704.102. RULES AUTHORIZING ACCEPTANCE OF EXISTING
10 SURVEY. (a) The commissioner by rule may authorize a title
11 insurance company providing area and boundary coverage to accept an
12 existing real property survey as provided by this section.

13 (b) A title insurance company may accept an existing real
14 property survey rather than requiring a new survey if,
15 notwithstanding the age of the survey or the identity of the person
16 for whom the survey was prepared, the company is willing to accept:

17 (1) evidence of the existing survey; and

18 (2) an affidavit prescribed by the commissioner that
19 verifies the existing survey. (V.T.I.C. Art. 9.07C, Sec. (b).)

20 Sec. 2704.103. CERTAIN DISCRIMINATION PROHIBITED. A title
21 insurance company may not discriminate in providing area and
22 boundary coverage in connection with residential real property
23 solely because:

24 (1) the real property is platted or unplatted; or

25 (2) a municipality did not accept a subdivision plat
26 relating to the real property before September 1, 1975. (V.T.I.C.
27 Art. 9.07C, Sec. (c).)

1 Sec. 2704.104. INDEMNITY PROHIBITED. A title insurance
2 company may not require an indemnity from a seller, buyer,
3 borrower, or lender to provide area and boundary coverage.
4 (V.T.I.C. Art. 9.07C, Sec. (d).)

5 SECTION 7. TITLE 13, INSURANCE CODE. The Insurance Code is
6 amended by adding Title 13 to read as follows:

7 TITLE 13. REGULATION OF PROFESSIONALS

8 SUBTITLE A. GENERAL PROVISIONS

9 CHAPTER 4001. AGENT LICENSING IN GENERAL

10 CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

11 CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL

12 CHAPTER 4004. CONTINUING EDUCATION

13 CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS,

14 AND SANCTIONS

15 CHAPTER 4006. DISABILITY PROBATION OF AGENTS

16 [Chapters 4007-4050 reserved for expansion]

17 SUBTITLE B. AGENTS

18 CHAPTER 4051. PROPERTY AND CASUALTY AGENTS

19 CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS

20 CHAPTER 4053. MANAGING GENERAL AGENTS

21 CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

22 CHAPTER 4055. SPECIALTY AGENTS

23 CHAPTER 4056. NONRESIDENT AGENTS

24 [Chapters 4057-4100 reserved for expansion]

25 SUBTITLE C. ADJUSTERS

26 CHAPTER 4101. INSURANCE ADJUSTERS

27 [Chapters 4102-4150 reserved for expansion]

SUBTITLE D. OTHER PROFESSIONALS

CHAPTER 4151. THIRD-PARTY ADMINISTRATORS

CHAPTER 4152. REINSURANCE INTERMEDIARIES

CHAPTER 4153. RISK MANAGERS

TITLE 13. REGULATION OF PROFESSIONALS

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 4001. AGENT LICENSING IN GENERAL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4001.001. PURPOSE

Sec. 4001.002. APPLICABILITY

Sec. 4001.003. DEFINITIONS

Sec. 4001.004. LIMITED LIABILITY COMPANIES

Sec. 4001.005. RULES

Sec. 4001.006. FEES

Sec. 4001.007. INVESTIGATION OF ALLEGED VIOLATIONS

Sec. 4001.008. COMMISSIONER AGENT FOR SERVICE OF PROCESS

Sec. 4001.009. REFERENCES TO OTHER LAW

[Sections 4001.010-4001.050 reserved for expansion]

SUBCHAPTER B. ACTS CONSTITUTING ACTING AS AGENT;

CONSEQUENCES OF AGENT'S ACTIONS

Sec. 4001.051. ACTS CONSTITUTING ACTING AS AGENT

Sec. 4001.052. SOLICITOR OF APPLICATION FOR INSURANCE

CONSIDERED AGENT OF INSURER

Sec. 4001.053. PERSONAL LIABILITY FOR ACTING AS

AGENT

Sec. 4001.054. LIABILITY OF AGENT AND INSURER FOR

TAXES

[Sections 4001.055-4001.100 reserved for expansion]

SUBCHAPTER C. LICENSE REQUIREMENTS

Sec. 4001.101. LICENSE OR CERTIFICATE OF AUTHORITY
REQUIRED

Sec. 4001.102. LICENSE APPLICATION

Sec. 4001.103. FAILURE TO PROVIDE COMPLETE SET OF
FINGERPRINTS: GROUND FOR DENIAL OF
APPLICATION

Sec. 4001.104. ISSUANCE OF LICENSE: INTENT TO ACTIVELY
ENGAGE IN BUSINESS OF INSURANCE FOR
GENERAL PUBLIC

Sec. 4001.105. ISSUANCE OF LICENSE TO INDIVIDUAL

Sec. 4001.106. ISSUANCE OF LICENSE TO CORPORATION OR
PARTNERSHIP

Sec. 4001.107. ISSUANCE OF LICENSE TO DEPOSITORY
INSTITUTION

Sec. 4001.108. ISSUANCE OF LICENSE TO ENTITY CHARTERED BY
FEDERAL FARM CREDIT ADMINISTRATION

Sec. 4001.109. LICENSING OF SUBAGENT

[Sections 4001.110-4001.150 reserved for expansion]

SUBCHAPTER D. TEMPORARY LICENSE

Sec. 4001.151. AUTHORITY TO ISSUE TEMPORARY LICENSE

Sec. 4001.152. EXAMINATION NOT REQUIRED

Sec. 4001.153. APPLICATION FOR AND ISSUANCE OF TEMPORARY
LICENSE

Sec. 4001.154. AUTHORITY TO ACT AS AGENT PENDING RECEIPT
OF TEMPORARY LICENSE

1 Sec. 4001.155. TERM OF TEMPORARY LICENSE

2 Sec. 4001.156. RESTRICTION ON ISSUANCE OR RENEWAL OF
3 TEMPORARY LICENSE

4 Sec. 4001.157. OBTAINING CERTAIN COMMISSIONS PROHIBITED

5 Sec. 4001.158. REPLACEMENT OF EXISTING LIFE INSURANCE OR
6 ANNUITY CONTRACT PROHIBITED

7 Sec. 4001.159. SUSPENSION OR REVOCATION OF TEMPORARY
8 APPOINTMENT POWERS OF AGENT, INSURER,
9 OR HEALTH MAINTENANCE ORGANIZATION

10 Sec. 4001.160. TRAINING OF APPLICANT FOR TEMPORARY
11 LICENSE

12 Sec. 4001.161. DUTY TO ENSURE THAT APPLICANTS TAKE
13 LICENSING EXAMINATION

14 Sec. 4001.162. RESTRICTION ON APPOINTMENT OF TEMPORARY
15 LICENSE HOLDERS

16 [Sections 4001.163-4001.200 reserved for expansion]

17 SUBCHAPTER E. APPOINTMENT OF AGENT

18 Sec. 4001.201. APPOINTMENT REQUIRED

19 Sec. 4001.202. APPOINTMENT BY MULTIPLE INSURERS

20 Sec. 4001.203. TERM OF APPOINTMENT

21 Sec. 4001.204. AUTHORITY TO ACT AS AGENT BEFORE NOTICE OF
22 APPOINTMENT

23 Sec. 4001.205. APPOINTMENT OF SUBAGENT; TERMINATION

24 Sec. 4001.206. TERMINATION OF APPOINTMENT OF AGENT FOR
25 CAUSE; LIABILITY

26 [Sections 4001.207-4001.250 reserved for expansion]

27 SUBCHAPTER F. REGULATION OF AGENTS

1 Sec. 4001.251. INCORPORATION OF SOLE PROPRIETORSHIP

2 Sec. 4001.252. NOTIFICATION TO DEPARTMENT OF CERTAIN
3 INFORMATION

4 Sec. 4001.253. RESTRICTION ON ACQUISITION OF OWNERSHIP
5 INTEREST IN ENTITY LICENSED AS AGENT

6 Sec. 4001.254. MAINTENANCE OF QUALIFICATIONS

7 Sec. 4001.255. MAINTENANCE OF RECORDS

8 [Sections 4001.256-4001.300 reserved for expansion]

9 SUBCHAPTER G. OTHER PERSONS WHO MAY

10 SHARE IN PROFITS OF AGENCY

11 Sec. 4001.301. PROFITS AFTER DEATH OF AGENT WHO IS

12 MEMBER OF AGENCY PARTNERSHIP

13 Sec. 4001.302. PROFITS AFTER DEATH OF AGENT WHO IS SOLE

14 PROPRIETOR

15 Sec. 4001.303. PROFITS AFTER DEATH OF SHAREHOLDER OF

16 CORPORATE AGENCY

17 Sec. 4001.304. TRANSFER OF INTEREST IN AGENCY BY AGENT WHO

18 IS SOLE PROPRIETOR

19 Sec. 4001.305. TRANSFER OF INTEREST IN AGENCY BY SHAREHOLDER

20 OF CORPORATE AGENCY

21 CHAPTER 4001. AGENT LICENSING IN GENERAL

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Sec. 4001.001. PURPOSE. It is the intent of the legislature
24 to:

25 (1) simplify and reform the regulation of agents and
26 other persons regulated under this title in this state by
27 consolidating the kinds of licenses issued to those persons under

1 this title; and

2 (2) promote uniformity in the licensing, examination,
3 continuing education, and disciplinary requirements for those
4 persons in this state and with other states. (V.T.I.C. Art. 21.01,
5 Sec. 1.)

6 Sec. 4001.002. APPLICABILITY. (a) Except as otherwise
7 provided by this code, this title applies to each person licensed
8 under:

- 9 (1) Subchapter H, Chapter 885;
10 (2) Subchapter F, Chapter 911;
11 (3) Section 912.251;
12 (4) Subchapter E, Chapter 981;
13 (5) Subchapter D, Chapter 1152;
14 (6) Subchapter C or D of this chapter;
15 (7) Subtitle B, C, or D of this title;
16 (8) Article 23.23A; or
17 (9) Subsection (c), Article 5.13-1.

18 (b) This title does not apply to:

19 (1) a resident of this state who arbitrates in the
20 adjustment of losses between an insurer and an insured, a marine
21 adjuster who adjusts particular or general average losses of
22 vessels or cargoes if the adjuster paid an occupation tax of \$200
23 for the year in which the adjustment is made, or a practicing
24 attorney at law in this state, acting in the regular transaction of
25 the person's business as an attorney at law, who is not a local
26 agent and is not acting as an adjuster for an insurer;

27 (2) a full-time home office salaried employee of an

insurer authorized to engage in the business of insurance in this state, other than an employee who solicits or receives an application for the sale of insurance through an oral, written, or electronic communication in accordance with Subchapter G, Chapter 4051;

(3) an attorney in fact or the traveling salaried representative of a reciprocal or interinsurance exchange admitted to engage in the business of insurance in this state as to business transacted through the attorney in fact or salaried representative;

(4) the attorney in fact for a Lloyd's plan;

(5) the group motor vehicle insurance business or the group motor vehicle department of a company engaged in that business; or

(6) a salaried employee who is not involved in soliciting or negotiating insurance in the office of an agent and who devotes the employee's full time to clerical and administrative services, including the incidental taking of information from customers and receipt of premiums in the office of an agent, if:

(A) the employee does not receive any commissions; and

(B) the employee's compensation is not varied by the volume of premiums taken and received. (V.T.I.C. Art. 21.01, Sec. 3; Art. 21.02, Sec. (a) (part); Art. 21.07, Sec. 1(b).)

Sec. 4001.003. DEFINITIONS. Unless the context clearly indicates otherwise, in this title:

(1) "Agent" means a person who is an authorized agent of an insurer or health maintenance organization, a subagent, and

1 any other person who performs the acts of an agent, whether through
2 an oral, written, electronic, or other form of communication, by
3 soliciting, negotiating, procuring, or collecting a premium on an
4 insurance or annuity contract, or who represents or purports to
5 represent a health maintenance organization, including a health
6 maintenance organization offering only a single health care service
7 plan, in soliciting, negotiating, procuring, or effectuating
8 membership in the health maintenance organization. The term does
9 not include:

10 (A) a regular salaried officer or employee of an
11 insurer, health maintenance organization, or agent who:

12 (i) devotes substantially all of the
13 officer's or employee's time to activities other than the
14 solicitation of applications for insurance, annuity contracts, or
15 memberships;

16 (ii) does not receive a commission or other
17 compensation directly dependent on the business obtained; and

18 (iii) does not solicit or accept from the
19 public applications for insurance, annuity contracts, or
20 memberships;

21 (B) an employer or an employer's officer or
22 employee or a trustee of an employee benefit plan, to the extent
23 that the employer, officer, employee, or trustee is engaged in the
24 administration or operation of an employee benefits program
25 involving the use of insurance or annuities issued by an insurer or
26 memberships issued by a health maintenance organization, if the
27 employer, officer, employee, or trustee is not directly or

1 indirectly compensated by the insurer or health maintenance
2 organization issuing the insurance or annuity contracts or
3 memberships;

4 (C) except as otherwise provided by this code, a
5 depository institution, or an officer or employee of a depository
6 institution, to the extent that the depository institution or
7 officer or employee collects and remits premiums or charges by
8 charging those premiums or charges against accounts of depositors
9 on the orders of those depositors; or

10 (D) a person or the employee of a person who has
11 contracted to provide administrative, management, or health care
12 services to a health maintenance organization and who is
13 compensated for those services by the payment of an amount computed
14 as a percentage of the revenues, net income, or profit of the health
15 maintenance organization, if that method of compensation is the
16 sole basis for subjecting that person or the employee of the person
17 to this title.

18 (2) "Control" means the power to direct or cause the
19 direction of the management and policies of a license holder,
20 whether directly or indirectly. For the purposes of this title, a
21 person is considered to control:

22 (A) a corporate license holder if the person,
23 individually or acting with others, directly or indirectly, holds
24 with the power to vote, owns, or controls, or holds proxies
25 representing, at least 10 percent of the voting stock or voting
26 rights of the corporate license holder; or

27 (B) a partnership if the person through a right

1 to vote or through any other right or power exercises rights in the
2 management, direction, or conduct of the business of the
3 partnership.

4 (3) "Corporation" means a legal entity that is
5 organized under the business corporation laws or limited liability
6 company laws of this state or another state and that has as one of
7 its purposes the authority to act as an agent.

8 (4) "Depository institution" means:

9 (A) a bank or savings association as defined by
10 12 U.S.C. Section 1813, as amended;

11 (B) a foreign bank that maintains a branch,
12 agency, or commercial lending company in the United States;

13 (C) a federal or state credit union as defined by
14 12 U.S.C. Section 1752, as amended;

15 (D) a bank branch; or

16 (E) a bank subsidiary, as defined by state or
17 federal law.

18 (5) "Individual" means a natural person. The term
19 includes a resident or a nonresident of this state.

20 (6) "Insurer" means an insurance company or insurance
21 carrier regulated by the department. The term includes:

22 (A) a stock life, health, or accident insurance
23 company;

24 (B) a mutual life, health, or accident insurance
25 company;

26 (C) a stock fire or casualty insurance company;

27 (D) a mutual fire or casualty insurance company;

- (E) a Mexican casualty insurance company;
- (F) a Lloyd's plan;
- (G) a reciprocal or interinsurance exchange;
- (H) a fraternal benefit society;
- (I) a stipulated premium company;
- (J) a nonprofit or for-profit legal services corporation;
- (K) a statewide mutual assessment company;
- (L) a local mutual aid association;
- (M) a local mutual burial association;
- (N) an association exempt under Section 887.102;
- (O) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;
- (P) a health maintenance organization;
- (Q) a county mutual insurance company; and
- (R) a farm mutual insurance company.

(7) "Partnership" means an association of two or more persons organized under the partnership laws or limited liability partnership laws of this state or another state. The term includes a general partnership, limited partnership, limited liability partnership, and limited liability limited partnership.

(8) "Person" means an individual, partnership, corporation, or depository institution.

(9) "Subagent" means a person engaging in activities described under Subdivision (1) who acts for or on behalf of an agent, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, or procuring an

1 insurance or annuity contract or health maintenance organization
2 membership, or collecting premiums or charges on an insurance or
3 annuity contract or health maintenance organization membership,
4 without regard to whether the subagent is designated by the agent as
5 a subagent or by any other term. A subagent is an agent for all
6 purposes of this title, and a reference to an agent in this title,
7 Chapter 21, or a provision listed in Section 4001.009 includes a
8 subagent without regard to whether a subagent is specifically
9 mentioned. (V.T.I.C. Art. 21.07, Secs. 1A(1), (2), (3) (part),
10 (4), (5), (6), (7), (8), (9).)

11 Sec. 4001.004. LIMITED LIABILITY COMPANIES. The licensing
12 and regulation of a limited liability company are subject to each
13 provision of this title that applies to a corporation licensed
14 under this title. (V.T.I.C. Art. 21.07, Sec. 1A(3) (part).)

15 Sec. 4001.005. RULES. The commissioner may adopt rules
16 necessary to implement this title and to meet the minimum
17 requirements of federal law, including regulations. (V.T.I.C. Art.
18 21.01, Sec. 4.)

19 Sec. 4001.006. FEES. (a) The department shall collect from
20 each agent of an insurer writing insurance in this state under this
21 code:

22 (1) a nonrefundable license fee; and
23 (2) a nonrefundable appointment fee for each
24 appointment of the agent by an insurer.

25 (b) The department shall deposit the fees described by
26 Subsection (a), together with other license fees, examination fees,
27 and license renewal fees, to the credit of the Texas Department of

1 Insurance operating account.

2 (c) The department shall set the fees in amounts reasonable
3 and necessary to implement this title and may use any portion of
4 those fees to enforce this title. (V.T.I.C. Art. 21.07, Secs.
5 6C(a), (b) (part), (c).)

6 Sec. 4001.007. INVESTIGATION OF ALLEGED VIOLATIONS. (a)
7 The department may:

8 (1) employ persons as the department considers
9 necessary to investigate and make reports regarding alleged
10 violations of this code and misconduct on the part of agents; and

11 (2) pay the salaries and expenses of those persons and
12 office employees and other expenses necessary to enforce this title
13 from the fees described by Section 4001.006.

14 (b) A person employed by the department under this section
15 may:

16 (1) administer the oath to, and examine under oath,
17 any person considered necessary in gathering information and
18 evidence; and

19 (2) have that information and evidence reduced to
20 writing if considered necessary.

21 (c) All expenses related to the activities described by
22 Subsection (b) shall be paid from the fees described by Section
23 4001.006. (V.T.I.C. Art. 21.07, Sec. 6C(b) (part).)

24 Sec. 4001.008. COMMISSIONER AGENT FOR SERVICE OF PROCESS.
25 In the manner provided by Subchapter C, Chapter 804, the
26 commissioner is a corporation's or partnership's agent for service
27 of process in a legal proceeding against the corporation or

partnership if:

(1) the corporation or partnership is licensed to engage in business in this state and does not appoint or maintain an agent for service in this state;

(2) an agent for service cannot be found with reasonable diligence; or

(3) the license of the corporation or partnership is revoked. (V.T.I.C. Art. 21.07, Sec. 2(r).)

Sec. 4001.009. REFERENCES TO OTHER LAW. (a) As referenced in Section 4001.003(9), a reference to an agent in the following laws includes a subagent without regard to whether a subagent is specifically mentioned:

(1) Chapters 281, 523, 541-556, 558, 702, 703, 705, 821, 823-825, 827, 828, 844, 1108, 1205-1209, 1352, 1353, 1357, 1358, 1360-1363, 1369, 1453-1455, and 1503;

(2) Subchapter C, Chapter 521;

(3) Subchapter A, Chapter 557;

(4) Subchapter B, Chapter 805;

(5) Subchapter D, Chapter 1103;

(6) Subchapters B, C, D, and E, Chapter 1204, excluding Sections 1204.153 and 1204.154;

(7) Subchapter B, Chapter 1366;

(8) Subchapters B, C, and D, Chapter 1367, excluding Section 1367.053(c);

(9) Subchapters A, C, D, E, F, H, and I, Chapter 1451;

(10) Subchapter B, Chapter 1452;

(11) Sections 982.001, 982.002, 982.004, 982.052,

982.102, 982.103, 982.104, 982.106, 982.107, 982.108, 982.110,
982.111, and 982.112;

(12) Subchapters D, E, and F, Chapter 982;

(13) Section 1101.003(a); and

(14) Chapter 107, Occupations Code.

(b) As referenced in Section 4001.051(b), a person is the agent of the insurer for which the act is done or risk is taken in the manner provided by that subsection for purposes of the liabilities, duties, requirements, and penalties provided by a law listed in Subsection (a). (New.)

[Sections 4001.010-4001.050 reserved for expansion]

SUBCHAPTER B. ACTS CONSTITUTING ACTING AS AGENT;

CONSEQUENCES OF AGENT'S ACTIONS

Sec. 4001.051. ACTS CONSTITUTING ACTING AS AGENT. (a) This section applies regardless of whether an insurer is incorporated under the laws of this state or another state or a foreign government.

(b) Regardless of whether the act is done at the request of or by the employment of an insurer, broker, or other person, a person is the agent of the insurer for which the act is done or risk is taken for purposes of the liabilities, duties, requirements, and penalties provided by this title, Chapter 21, or a provision listed in Section 4001.009 if the person:

(1) solicits insurance on behalf of the insurer;

(2) receives or transmits other than on the person's own behalf an application for insurance or an insurance policy to or from the insurer;

1 (3) advertises or otherwise gives notice that the
2 person will receive or transmit an application for insurance or an
3 insurance policy;

4 (4) receives or transmits an insurance policy of the
5 insurer;

6 (5) examines or inspects a risk;

7 (6) receives, collects, or transmits an insurance
8 premium;

9 (7) makes or forwards a diagram of a building;

10 (8) takes any other action in the making or
11 consummation of an insurance contract for or with the insurer other
12 than on the person's own behalf; or

13 (9) examines into, adjusts, or aids in adjusting a
14 loss for or on behalf of the insurer.

15 (c) This section does not authorize an agent to orally, in
16 writing, or otherwise alter or waive a term or condition of an
17 insurance policy or an application for an insurance policy.

18 (d) The referral by an unlicensed person of a customer or
19 potential customer to an agent is not an act of an agent under this
20 section unless the unlicensed person discusses specific insurance
21 policy terms or conditions with the customer or potential customer.

22 (V.T.I.C. Art. 21.02, Secs. (a) (part), (b).)

23 Sec. 4001.052. SOLICITOR OF APPLICATION FOR INSURANCE
24 CONSIDERED AGENT OF INSURER. (a) A person who solicits an
25 application for life, accident, or health insurance or property or
26 casualty insurance is considered the agent of the insurer issuing a
27 policy on the application and not the agent of the insured in any

1 controversy between the insurer and the insured, the insured's
2 beneficiary, or the insured's dependents.

3 (b) The agent may not alter or waive a term or condition of
4 the application or policy. (V.T.I.C. Art. 21.04.)

5 Sec. 4001.053. PERSONAL LIABILITY FOR ACTING AS AGENT. A
6 person who takes an action listed in Section 4001.051 for or on
7 behalf of an insurer before the insurer complies with the
8 requirements of the laws of this state is personally liable to the
9 holder of any insurance policy with respect to which the action was
10 taken for any loss covered by the insurance policy. (V.T.I.C. Art.
11 21.02, Sec. (a) (part).)

12 Sec. 4001.054. LIABILITY OF AGENT AND INSURER FOR TAXES.
13 (a) If a person takes an action in this state listed in Section
14 4001.051 for or on behalf of an insurer, the insurer is considered
15 to be engaged in the business of insurance in this state and is
16 subject to the same state, county, and municipal taxes as an insurer
17 that has been legally qualified and admitted to engage in the
18 business of insurance in this state.

19 (b) Taxes shall be assessed against and collected from an
20 insurer under this section in the same manner as taxes are assessed
21 against and collected from insurers that are legally qualified and
22 admitted to engage in the business of insurance in this state.

23 (c) A person who takes an action by means of which an insurer
24 is considered to be engaged in the business of insurance in this
25 state under this section is personally liable for any taxes
26 assessed against the insurer under this section. (V.T.I.C. Art.
27 21.03.)

[Sections 4001.055-4001.100 reserved for expansion]

SUBCHAPTER C. LICENSE REQUIREMENTS

Sec. 4001.101. LICENSE OR CERTIFICATE OF AUTHORITY REQUIRED. (a) Unless the person holds a license or certificate of authority issued by the department, a person may not:

(1) solicit or receive an application for insurance in this state; or

(2) aid in the transaction of the business of an insurer.

(b) A person may not act as an agent of a health maintenance organization or other type of insurer authorized to engage in business in this state unless the person holds a license issued by the department as provided by this title.

(c) An insurer described by Subsection (b) may not appoint a person to act as its agent unless the person holds a license under this title.

(d) This subchapter does not permit an employee or agent of a corporation or partnership to perform an act of an agent under this title without obtaining a license. (V.T.I.C. Art. 21.01, Sec. 2; Art. 21.07, Secs. 1(a) (part), 2(j).)

Sec. 4001.102. LICENSE APPLICATION. (a) To become an agent for an insurer or health maintenance organization, a person must submit to the department a completed license application in the form required by the department.

(b) The commissioner by rule shall prescribe the requirements for a properly completed application. (V.T.I.C. Art. 21.07, Secs. 2(a), (b).)

1 Sec. 4001.103. FAILURE TO PROVIDE COMPLETE SET OF
2 FINGERPRINTS: GROUND FOR DENIAL OF APPLICATION. (a) In this
3 section, "authorization" means any authorization issued by the
4 department to engage in an activity regulated under this title,
5 including a license or permit.

6 (b) The department may deny an application for an
7 authorization if the applicant fails to provide a complete set of
8 fingerprints on request by the department. (V.T.I.C. Art. 1.10C
9 (part).)

10 Sec. 4001.104. ISSUANCE OF LICENSE: INTENT TO ACTIVELY
11 ENGAGE IN BUSINESS OF INSURANCE FOR GENERAL PUBLIC. (a) The
12 department may not issue a license as an agent to write any line of
13 insurance unless the department determines that:

14 (1) the applicant is or intends to be actively engaged
15 in the soliciting or writing of insurance for the general public and
16 is to be actively engaged in the business of insurance; and

17 (2) the application is not made to evade the laws
18 against rebating and discrimination, either for the applicant or
19 for another person.

20 (b) This subchapter does not prohibit an applicant from
21 insuring property that the applicant owns or in which the applicant
22 has an interest. It is the intent of this subchapter to prohibit
23 coercion of insurance and to preserve to each individual the right
24 to choose that individual's own agent or insurer and to prohibit the
25 licensing of an applicant to engage in the business of insurance
26 principally to handle business that the applicant controls only
27 through ownership, mortgage, sale, family relationship, or

1 employment. An applicant for an original license must have a bona
2 fide intention to engage in business in which, in any calendar year,
3 at least 25 percent of the total volume of premiums is derived from
4 persons other than the applicant and from property other than that
5 on which the applicant controls the placing of insurance through
6 ownership, mortgage, sale, family relationship, or employment.

7 (c) The department may not deny a license application solely
8 on the ground that the applicant will act only part-time as an
9 agent. (V.T.I.C. Art. 21.07, Secs. 2(c), (d), (e).)

10 Sec. 4001.105. ISSUANCE OF LICENSE TO INDIVIDUAL. The
11 department shall issue a license to an individual to engage in
12 business as an agent if the department determines that the
13 individual:

14 (1) is at least 18 years of age;

15 (2) has passed the licensing examination required
16 under this code within the past 12 months;

17 (3) has not committed an act for which a license may be
18 denied under Subchapter C, Chapter 4005; and

19 (4) has submitted the application, appropriate fees,
20 and any other information required by the department. (V.T.I.C.
21 Art. 21.07, Sec. 2(f).)

22 Sec. 4001.106. ISSUANCE OF LICENSE TO CORPORATION OR
23 PARTNERSHIP. (a) In this section, "customer" means a person or
24 firm to which a corporation or partnership sells or attempts to sell
25 an insurance policy or from which a corporation or partnership
26 accepts an application for insurance.

27 (b) The department shall issue a license to a corporation or

1 partnership if the department determines that:

2 (1) the corporation or partnership is:

3 (A) organized under the laws of this state or
4 another state;

5 (B) admitted to engage in business in this state
6 by the secretary of state, if required; and

7 (C) authorized by its articles of incorporation
8 or its partnership agreement to act as an agent;

9 (2) at least one officer of the corporation or one
10 active partner of the partnership and all other persons performing
11 any acts of an agent on behalf of the corporation or partnership in
12 this state are individually licensed by the department separately
13 from the corporation or partnership;

14 (3) the corporation or partnership will have the
15 ability to pay any amount up to \$25,000 that it might become legally
16 obligated to pay under a claim made against it by a customer and
17 caused by a negligent act, error, or omission of the corporation or
18 partnership or a person for whose acts the corporation or
19 partnership is legally liable in the conduct of its business under
20 this code;

21 (4) if engaged in the business of insurance, the
22 corporation or partnership intends to be actively engaged in that
23 business as required under Section 4001.104(a);

24 (5) each location from which the corporation or
25 partnership will engage in business in this state under authority
26 of a license issued by the department is registered separately with
27 the department;

1 (6) the corporation or partnership has submitted the
2 application, appropriate fees, and any other information required
3 by the department; and

4 (7) an officer, director, member, manager, partner, or
5 other person who has the right or ability to control the corporation
6 or partnership has not:

7 (A) had a license suspended or revoked or been
8 the subject of any other disciplinary action by a financial or
9 insurance regulator of this state, another state, or the United
10 States; or

11 (B) committed an act for which a license may be
12 denied under Subchapter C, Chapter 4005.

13 (c) A corporation or partnership shall maintain the ability
14 to pay a claim described by Subsection (b)(3) by obtaining:

15 (1) an errors and omissions policy insuring the
16 corporation or partnership against errors and omissions in at least
17 the amount of \$250,000, with a deductible of not more than 10
18 percent of the full amount of the policy, issued by:

19 (A) an insurer authorized to engage in the
20 business of insurance in this state; or

21 (B) if a policy cannot be obtained from an
22 insurer authorized to engage in the business of insurance in this
23 state, a surplus lines insurer under Chapter 981; or

24 (2) a bond in the principal amount of \$25,000 that is:

25 (A) executed by the corporation or partnership as
26 principal and a surety company authorized to engage in business in
27 this state as surety;

1 (B) payable to the department for the use and
2 benefit of customers of the corporation or partnership; and

3 (C) conditioned that the corporation or
4 partnership shall pay any final judgment recovered against it by a
5 customer.

6 (d) A binding commitment to issue a policy or bond described
7 by Subsection (c) is sufficient in connection with an application
8 for a license. (V.T.I.C. Art. 21.07, Sec. 2(i) (part).)

9 Sec. 4001.107. ISSUANCE OF LICENSE TO DEPOSITORY
10 INSTITUTION. The department shall issue a license to a depository
11 institution in the manner provided by this subchapter for the
12 licensing of a corporation. (V.T.I.C. Art. 21.07, Sec. 2(m).)

13 Sec. 4001.108. ISSUANCE OF LICENSE TO ENTITY CHARTERED BY
14 FEDERAL FARM CREDIT ADMINISTRATION. The department may license an
15 entity chartered by the federal Farm Credit Administration under
16 the farm credit system established under 12 U.S.C. Section 2001 et
17 seq., as amended, to solicit insurance in this state as provided by
18 12 U.S.C. Section 2218, as amended. The department shall issue the
19 license in the manner provided by this subchapter for the licensing
20 of a corporation. (V.T.I.C. Art. 21.07, Sec. 2(v).)

21 Sec. 4001.109. LICENSING OF SUBAGENT. A subagent must be
22 licensed to write each line of insurance that the subagent is
23 employed to write, but is not required to hold each kind of license
24 issued to the agent for whom the subagent acts. (V.T.I.C. Art.
25 21.07, Sec. 2(u).)

26 [Sections 4001.110-4001.150 reserved for expansion]

27 SUBCHAPTER D. TEMPORARY LICENSE

1 Sec. 4001.151. AUTHORITY TO ISSUE TEMPORARY LICENSE. The
2 department may issue a temporary agent's license to an applicant
3 for a license under Section 4001.102 who is being considered for
4 appointment as an agent by another agent, an insurer, or a health
5 maintenance organization. (V.T.I.C. Art. 21.07, Sec. 3A(a)
6 (part).)

7 Sec. 4001.152. EXAMINATION NOT REQUIRED. An applicant is
8 not required to pass a written examination to obtain a temporary
9 license. (V.T.I.C. Art. 21.07, Sec. 3A(a) (part).)

10 Sec. 4001.153. APPLICATION FOR AND ISSUANCE OF TEMPORARY
11 LICENSE. The department shall issue a temporary license
12 immediately on receipt of a properly completed application executed
13 by the applicant in the form required by Section 4001.102 and
14 accompanied by:

15 (1) the nonrefundable filing fee set by the
16 department; and

17 (2) a certificate signed by an officer or properly
18 authorized representative of an agent, insurer, or health
19 maintenance organization stating that:

20 (A) the applicant is being considered for
21 appointment by the agent, insurer, or health maintenance
22 organization as its full-time agent;

23 (B) the agent, insurer, or health maintenance
24 organization desires that the applicant be issued a temporary
25 license; and

26 (C) the applicant will complete training as
27 prescribed by Section 4001.160 under the agent's, insurer's, or

1 health maintenance organization's supervision. (V.T.I.C. Art.
2 21.07, Sec. 3A(a) (part).)

3 Sec. 4001.154. AUTHORITY TO ACT AS AGENT PENDING RECEIPT OF
4 TEMPORARY LICENSE. If a temporary license is not received from the
5 department before the eighth day after the date the application,
6 nonrefundable fee, and certificate are delivered or mailed to the
7 department and the appropriate agent, insurer, or health
8 maintenance organization has not been notified that the application
9 is denied, the agent, insurer, or health maintenance organization
10 may assume that the temporary license will be issued and the
11 applicant may proceed to act as an agent. (V.T.I.C. Art. 21.07,
12 Sec. 3A(b).)

13 Sec. 4001.155. TERM OF TEMPORARY LICENSE. A temporary
14 license is valid for 90 days after the date of issuance. (V.T.I.C.
15 Art. 21.07, Sec. 3A(a) (part).)

16 Sec. 4001.156. RESTRICTION ON ISSUANCE OR RENEWAL OF
17 TEMPORARY LICENSE. (a) A temporary license may not be issued to or
18 renewed by the same person more than once in a consecutive six-month
19 period.

20 (b) A temporary license may not be issued to a person who
21 does not intend to apply for a license to sell insurance or
22 memberships to the general public. (V.T.I.C. Art. 21.07, Secs.
23 3A(c), (d).)

24 Sec. 4001.157. OBTAINING CERTAIN COMMISSIONS PROHIBITED.
25 (a) A temporary license holder may not obtain a commission on a
26 sale made to a person who has a family, employment, or business
27 relationship with the temporary license holder.

1 (b) An agent, insurer, or health maintenance organization
2 may not knowingly pay, directly or indirectly, to a temporary
3 license holder, and a temporary license holder may not receive or
4 accept, a commission on the sale of a contract of insurance or
5 membership covering:

6 (1) the temporary license holder;

7 (2) a person related to the temporary license holder
8 by consanguinity or affinity;

9 (3) a person who is or has been during the past six
10 months the temporary license holder's employer, either as an
11 individual or as a member of a partnership, association, firm, or
12 corporation; or

13 (4) a person who is or has been during the past six
14 months an employee of the temporary license holder. (V.T.I.C. Art.
15 21.07, Sec. 3A(e).)

16 Sec. 4001.158. REPLACEMENT OF EXISTING LIFE INSURANCE OR
17 ANNUITY CONTRACT PROHIBITED. (a) A temporary license holder who is
18 acting under the authority of that license may not:

19 (1) engage in an insurance solicitation, sale, or
20 other agency transaction that the license holder knows or should
21 know will result or is intended to result in:

22 (A) the purchase of a new life insurance or
23 annuity contract; and

24 (B) any of the following actions with regard to
25 an existing individual life insurance or annuity contract as a
26 result of that purchase:

27 (i) termination of the contract by lapse,

1 forfeiture, surrender, or other means;

2 (ii) conversion of the contract to reduced
3 paid-up insurance, continuation of the contract as extended term
4 insurance, or reduction in value of the contract by the use of
5 nonforfeiture benefits or other policy values;

6 (iii) amendment of the contract to reduce:

7 (a) benefits; or

8 (b) the term for which coverage would
9 otherwise remain in force or for which benefits would be paid;

10 (iv) reissuance of the contract with a
11 reduction in cash value; or

12 (v) pledge of the contract as collateral or
13 subjection of the contract to borrowing, whether in a single loan or
14 under a schedule of borrowing, for amounts that in the aggregate
15 exceed 25 percent of the loan value prescribed by the contract; or

16 (2) directly or indirectly receive a commission or
17 other compensation that results or may result from a solicitation,
18 sale, or other agency transaction described by Subdivision (1).

19 (b) A person who holds a permanent license may not
20 circumvent or attempt to circumvent the intent of this section by
21 acting for or with a person holding a temporary license. (V.T.I.C.
22 Art. 21.07, Sec. 3A(f).)

23 Sec. 4001.159. SUSPENSION OR REVOCATION OF TEMPORARY
24 APPOINTMENT POWERS OF AGENT, INSURER, OR HEALTH MAINTENANCE
25 ORGANIZATION. (a) The department may suspend or revoke the
26 temporary appointment powers of an agent, insurer, or health
27 maintenance organization if, after notice and opportunity for

1 hearing, the department determines that the agent, insurer, or
2 health maintenance organization has abused the temporary
3 appointment powers.

4 (b) In determining whether abuse has occurred, the
5 department may consider:

6 (1) the number of temporary appointments made;

7 (2) the percentage of appointees taking the
8 examination required for licensing as an agent, as provided by
9 Section 4001.161; and

10 (3) the number of appointees who pass the examination.
11 (V.T.I.C. Art. 21.07, Sec. 3A(g) (part).)

12 Sec. 4001.160. TRAINING OF APPLICANT FOR TEMPORARY LICENSE.

13 (a) An agent, insurer, or health maintenance organization that is
14 considering appointment of a temporary license applicant as its
15 agent shall provide at least 40 hours of training to the applicant
16 not later than the 14th day after the date the application,
17 nonrefundable fee, and certificate are delivered or mailed to the
18 department.

19 (b) At least 10 hours of the training must be taught in a
20 classroom setting, including:

21 (1) an accredited college, university, junior
22 college, or community college;

23 (2) a business school; or

24 (3) a private institute or classes sponsored by the
25 agent, insurer, or health maintenance organization and
26 specifically established for that purpose.

27 (c) The training program must be designed to provide an

1 applicant with basic knowledge of:

2 (1) the broad principles of insurance, including the
3 licensing and regulatory laws of this state;

4 (2) the broad principles of health maintenance
5 organizations, including membership requirements and related
6 licensing and regulatory laws of this state; and

7 (3) the ethical obligations and duties of an agent.

8 (d) If the department determines under Section 4001.159
9 that an abuse of temporary appointment powers has occurred, the
10 department may require the affected agent, insurer, or health
11 maintenance organization to:

12 (1) file with the department a description of the
13 agent's, insurer's, or health maintenance organization's training
14 program; and

15 (2) obtain the approval of the department before
16 continuing to use the training program. (V.T.I.C. Art. 21.07,
17 Secs. 3A(a) (part), (h), (i).)

18 Sec. 4001.161. DUTY TO ENSURE THAT APPLICANTS TAKE
19 LICENSING EXAMINATION. An agent, insurer, or health maintenance
20 organization shall ensure that, during any two consecutive calendar
21 quarters, at least 70 percent of the agent's, insurer's, or health
22 maintenance organization's applicants for temporary licenses take
23 the required licensing examination. At least 50 percent of the
24 applicants taking the examination must pass the examination during
25 that period. (V.T.I.C. Art. 21.07, Sec. 3A(j).)

26 Sec. 4001.162. RESTRICTION ON APPOINTMENT OF TEMPORARY
27 LICENSE HOLDERS. An agent, insurer, or health maintenance

1 organization may not appoint more than 250 temporary license
2 holders during a calendar year. (V.T.I.C. Art. 21.07, Sec. 3A(k).)

3 [Sections 4001.163-4001.200 reserved for expansion]

4 SUBCHAPTER E. APPOINTMENT OF AGENT

5 Sec. 4001.201. APPOINTMENT REQUIRED. A person who obtains
6 a license under this title may not engage in business as an agent
7 unless the person has been appointed to act as an agent by an
8 insurer designated by the provisions of this code and authorized to
9 engage in business in this state. (V.T.I.C. Art. 21.07, Sec. 1(a)
10 (part).)

11 Sec. 4001.202. APPOINTMENT BY MULTIPLE INSURERS. (a)
12 Except as specifically prohibited by this code, an agent may
13 represent and act as an agent for more than one insurer.

14 (b) Not later than the 30th day after the effective date of
15 the appointment, the agent and the insurer involved shall notify
16 the department, on a form prescribed by the department, of any
17 additional appointment authorizing the agent to act as agent for
18 one or more additional insurers. The notice must be accompanied by
19 a nonrefundable fee in an amount set by the department for each
20 additional appointment for which the insurer applies. (V.T.I.C.
21 Art. 21.07, Sec. 6(a).)

22 Sec. 4001.203. TERM OF APPOINTMENT. (a) An appointment
23 authorizing an agent to act for an insurer continues in effect
24 without the necessity of renewal until the appointment is
25 terminated or withdrawn by the insurer or the agent.

26 (b) A renewal license issued to an agent authorizes the
27 agent to represent and act for each insurer for which the agent

1 holds an appointment until the appointment is terminated or
2 withdrawn, and the agent is considered to be the agent of each
3 appointing insurer for the purposes of this code. (V.T.I.C. Art.
4 21.07, Sec. 6(b) (part).)

5 Sec. 4001.204. AUTHORITY TO ACT AS AGENT BEFORE NOTICE OF
6 APPOINTMENT. An agent appointed under this subchapter may act on
7 behalf of the appointing insurer before the department receives the
8 notice filed under Section 4001.202(b). (V.T.I.C. Art. 21.07, Sec.
9 6(c).)

10 Sec. 4001.205. APPOINTMENT OF SUBAGENT; TERMINATION. (a)
11 A general life, accident, and health agent or a general property and
12 casualty agent appointed by an insurer authorized to engage in the
13 business of insurance in this state shall notify the department on a
14 form prescribed by the department if the agent appoints a subagent.
15 The notice must be accompanied by a nonrefundable fee in an amount
16 set by the department.

17 (b) An insurer is not required to separately appoint a
18 subagent who has been designated by an agent in a notice filed with
19 the department under Subsection (a).

20 (c) An agent who terminates the appointment of a subagent
21 for a reason other than for cause shall promptly report the
22 termination to the department. The termination ends the subagent's
23 authority to act for the agent or the insurer for whom the agent is
24 acting.

25 (d) Section 4001.206 applies to the termination of the
26 appointment of a subagent for cause. (V.T.I.C. Art. 21.07, Secs.
27 6(d), (e), (f).)

1 Sec. 4001.206. TERMINATION OF APPOINTMENT OF AGENT FOR
2 CAUSE; LIABILITY. (a) On termination of the appointment of an
3 agent for cause, the insurer or agent shall immediately file with
4 the department a statement of the facts relating to the termination
5 of the appointment and the date and cause of the termination. On
6 receipt of the statement, the department shall record the
7 termination of the appointment of that agent to represent the
8 insurer in this state.

9 (b) A document, record, statement, or other information
10 required to be made or disclosed to the department under this
11 section is a privileged and confidential communication and is not
12 admissible in evidence in a court action or proceeding except under
13 a subpoena issued by a court of record.

14 (c) A person, including an insurer or an employee or agent
15 of an insurer, who provides without malice information required to
16 be disclosed under this section is not liable for providing the
17 information. (V.T.I.C. Art. 21.07, Secs. 6(b) (part), 6B.)

18 [Sections 4001.207-4001.250 reserved for expansion]

19 SUBCHAPTER F. REGULATION OF AGENTS

20 Sec. 4001.251. INCORPORATION OF SOLE PROPRIETORSHIP. An
21 individual engaged in business as a sole proprietorship under a
22 license issued under this title may incorporate. The corporation
23 does not have greater license authority than that granted to the
24 license holder in the holder's individual capacity. (V.T.I.C. Art.
25 21.07, Sec. 2(g).)

26 Sec. 4001.252. NOTIFICATION TO DEPARTMENT OF CERTAIN
27 INFORMATION. (a) An individual licensed as an agent shall notify

1 the department on a monthly basis of:

- 2 (1) a change of the license holder's mailing address;
- 3 (2) a felony conviction of the license holder; or
- 4 (3) an administrative action taken against the license
- 5 holder by a financial or insurance regulator of this state, another
- 6 state, or the United States.

7 (b) A corporation or partnership licensed as an agent under

8 this title shall file under oath, on a form developed by the

9 department, biographical information for:

10 (1) each executive officer, director, or unlicensed

11 partner who administers the entity's operations in this state;

12 (2) each shareholder who is in control of the

13 corporation or partner who has the right or ability to control the

14 partnership; and

15 (3) if the corporation or partnership is owned, in

16 whole or in part, by another entity, each individual who is in

17 control of the parent entity.

18 (c) A corporation or partnership shall notify the

19 department not later than the 30th day after the date of:

20 (1) a felony conviction of a licensed agent of the

21 entity or an individual associated with the entity who is required

22 to file biographical information with the department;

23 (2) an event for which notification would be required

24 under Section 81.003; or

25 (3) the addition or removal of an officer, director,

26 partner, member, or manager. (V.T.I.C. Art. 21.07, Secs. 2(h),

27 (k), (l).)

1 Sec. 4001.253. RESTRICTION ON ACQUISITION OF OWNERSHIP
2 INTEREST IN ENTITY LICENSED AS AGENT. (a) A person may not acquire
3 in any manner an ownership interest in an entity licensed as an
4 agent under this title if the person is, or after the acquisition
5 would be, directly or indirectly in control of the license holder,
6 or otherwise acquire control of or exercise any control over the
7 license holder, unless the person has filed with the department
8 under oath:

9 (1) a biographical form for each person by whom or on
10 whose behalf the acquisition of control is to be effected;

11 (2) a statement certifying that no person who is
12 acquiring an ownership interest in or control of the license holder
13 has been the subject of a disciplinary action taken by a financial
14 or insurance regulator of this state, another state, or the United
15 States;

16 (3) a statement certifying that, immediately on the
17 change of control, the license holder will be able to satisfy the
18 requirements for the issuance of the license to solicit each line of
19 insurance for which it is licensed; and

20 (4) any additional information that the commissioner
21 by rule may prescribe as necessary or appropriate to the protection
22 of the insurance consumers of this state or as in the public
23 interest.

24 (b) The department may require a partnership, syndicate, or
25 other group that is required to file a statement under Subsection
26 (a) to provide the information under that subsection for each
27 partner of the partnership, each member of the syndicate or group,

1 and each person who controls the partner or member. If the partner,
2 member, or person is a corporation or the person required to file
3 the statement under Subsection (a) is a corporation, the department
4 may require that the information required under that subsection be
5 provided regarding:

- 6 (1) the corporation;
- 7 (2) each individual who is an executive officer or
8 director of the corporation; and
- 9 (3) each person who is directly or indirectly the
10 beneficial owner of more than 10 percent of the outstanding voting
11 securities of the corporation.

12 (c) The department may disapprove an acquisition of control
13 if, after notice and opportunity for hearing, the commissioner
14 determines that:

- 15 (1) immediately on the change of control the license
16 holder would not be able to satisfy the requirements for the
17 issuance of the license to solicit each line of insurance for which
18 it is presently licensed;
- 19 (2) the competence, trustworthiness, experience, and
20 integrity of the persons who would control the operation of the
21 license holder are such that it would not be in the interest of the
22 insurance consumers of this state to permit the acquisition of
23 control; or
- 24 (3) the acquisition of control would violate this code
25 or another law of this state, another state, or the United States.

26 (d) Notwithstanding Subsection (c), a change in control is
27 considered approved if the department has not proposed to deny the

requested change before the 61st day after the date the department receives all information required by this section. (V.T.I.C. Art. 21.07, Secs. 2(n), (o), (p), (q).)

Sec. 4001.254. MAINTENANCE OF QUALIFICATIONS. The department shall, in the manner provided by Subchapter C, Chapter 4005, revoke, suspend, or refuse to renew the license of a license holder who does not maintain the qualifications necessary to obtain the license. (V.T.I.C. Art. 21.07, Sec. 2(s).)

Sec. 4001.255. MAINTENANCE OF RECORDS. An agent shall maintain all insurance records, including all records relating to customer complaints, separate from the records of any other business in which the agent may be engaged. (V.T.I.C. Art. 21.07, Sec. 2(t).)

[Sections 4001.256-4001.300 reserved for expansion]

SUBCHAPTER G. OTHER PERSONS WHO MAY

SHARE IN PROFITS OF AGENCY

Sec. 4001.301. PROFITS AFTER DEATH OF AGENT WHO IS MEMBER OF AGENCY PARTNERSHIP. On the death of an agent who is a member of an agency partnership, the surviving spouse and children, if any, of the deceased partner, or a trust for the surviving spouse and children, may share in the profits of the agency partnership during the lifetime of the surviving spouse or children, as the case may be, as provided by:

(1) a written partnership agreement; or

(2) in the absence of a written agreement, an agreement by the surviving partner or partners and the surviving spouse, the trustee, and the legal representative of the surviving

1 children. (V.T.I.C. Art. 21.07, Sec. 2A(a).)

2 Sec. 4001.302. PROFITS AFTER DEATH OF AGENT WHO IS SOLE
3 PROPRIETOR. (a) On the death of an agent who is a sole proprietor,
4 unless otherwise provided by the probated will of the deceased
5 agent, the surviving spouse and children, if any, of the deceased
6 agent, or a trust for the surviving spouse or children, may share in
7 the profits of the agency business of the deceased agent during the
8 lifetime of the surviving spouse and children if the agency
9 business is continued by an agent.

10 (b) The surviving spouse and children or trust is not
11 required to qualify as an agent to share in the profits of the
12 agency but may not perform an act of an agent in connection with the
13 agency business without first being licensed as an agent.
14 (V.T.I.C. Art. 21.07, Sec. 2A(b) (part).)

15 Sec. 4001.303. PROFITS AFTER DEATH OF SHAREHOLDER OF
16 CORPORATE AGENCY. (a) On the death of a shareholder of a corporate
17 licensed agency, the surviving spouse and children, if any, of the
18 deceased shareholder, or a trust for the surviving spouse and
19 children, may share in the profits of the corporate agency during
20 the lifetime of the surviving spouse or children as provided by a
21 contract entered into by each shareholder and the corporation.

22 (b) The surviving spouse and children or trust is not
23 required to qualify as an agent to share in the profits of the
24 corporation but may not perform an act of an agent on behalf of the
25 corporation without qualifying as an agent. (V.T.I.C. Art. 21.07,
26 Sec. 2A(c) (part).)

27 Sec. 4001.304. TRANSFER OF INTEREST IN AGENCY BY AGENT WHO

1 IS SOLE PROPRIETOR. (a) An agent who is a sole proprietor may
2 transfer an interest in the agency to the agent's children, or a
3 trust for the agent's children, and may operate that interest for
4 their use and benefit. The children may share in the profits of the
5 agency during their lifetime.

6 (b) The children are not required to qualify as agents to
7 share in the profits of the agency but may not perform an act of an
8 agent in connection with the agency business without first being
9 licensed as agents. (V.T.I.C. Art. 21.07, Sec. 2A(b) (part).)

10 Sec. 4001.305. TRANSFER OF INTEREST IN AGENCY BY
11 SHAREHOLDER OF CORPORATE AGENCY. (a) A shareholder of a corporate
12 licensed agency may, if provided by a contract entered into by each
13 shareholder and the corporation, transfer an interest in the agency
14 to the shareholder's children or a trust for the shareholder's
15 children. The children or trust may share in the profits of the
16 agency to the extent of that interest during the children's
17 lifetime.

18 (b) The children or trust is not required to qualify as an
19 agent to share in the profits of the corporation but may not perform
20 an act of an agent on behalf of the corporation without qualifying
21 as an agent. (V.T.I.C. Art. 21.07, Sec. 2A(c) (part).)

22 CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

23 SUBCHAPTER A. GENERAL PROVISIONS

24 Sec. 4002.001. EXAMINATION REQUIRED

25 Sec. 4002.002. EXAMINATION FOR LIMITED LICENSE

26 Sec. 4002.003. EXEMPTIONS FROM EXAMINATION REQUIREMENT

27 Sec. 4002.004. ADVISORY BOARD

1 Sec. 4002.005. EXAMINATION FEE

2 Sec. 4002.006. BILINGUAL EXAMINATION

3 Sec. 4002.007. EXAMINATION RESULTS

4 [Sections 4002.008-4002.050 reserved for expansion]

5 SUBCHAPTER B. ADMINISTRATION OF EXAMINATION BY
6 TESTING SERVICE

7 Sec. 4002.051. ADMINISTRATION BY TESTING SERVICE

8 AUTHORIZED

9 Sec. 4002.052. AGREEMENT WITH TESTING SERVICE

10 Sec. 4002.053. HEARING REQUIRED BEFORE AGREEMENT

11 [Sections 4002.054-4002.100 reserved for expansion]

12 SUBCHAPTER C. DUTIES OF DEPARTMENT

13 Sec. 4002.101. ADMINISTRATION BY DEPARTMENT

14 Sec. 4002.102. RULES

15 Sec. 4002.103. CONTENT OF EXAMINATION QUESTIONS

16 CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

17 SUBCHAPTER A. GENERAL PROVISIONS

18 Sec. 4002.001. EXAMINATION REQUIRED. (a) Except as
19 otherwise provided by this code, an applicant for a license to act
20 as an agent in this state must:

21 (1) take a personal written examination prescribed by
22 the commissioner; and

23 (2) pass the examination to the satisfaction of the
24 department.

25 (b) The examination must determine the applicant's
26 competence with respect to:

27 (1) the type of insurance contracts for which the

1 applicant seeks a license;

2 (2) the laws of this state regulating the business of
3 insurance; and

4 (3) the ethical obligations and duties of an agent.
5 (V.T.I.C. Art. 21.01-1, Sec. 2(a).)

6 Sec. 4002.002. EXAMINATION FOR LIMITED LICENSE. (a) The
7 commissioner shall prescribe a limited written examination for an
8 applicant for a limited agent's license under Chapter 4051 or 4054.

9 (b) The examination must determine the applicant's
10 competence and understanding of:

11 (1) the basic principles of insurance contracts;

12 (2) the basic laws of this state regulating the
13 business of insurance; and

14 (3) the ethical obligations and duties of an agent.
15 (V.T.I.C. Art. 21.01-1, Sec. 2(c).)

16 Sec. 4002.003. EXEMPTIONS FROM EXAMINATION REQUIREMENT.

17 (a) The department may not require a person to take an examination
18 under this chapter if the person is:

19 (1) an applicant for the renewal of an unexpired
20 license issued by the department;

21 (2) an applicant whose license issued by the
22 department expired less than one year before the date of the
23 application, if the previous license was not denied, revoked, or
24 suspended by the commissioner;

25 (3) a partnership, corporation, or depository
26 institution;

27 (4) an applicant for a life, accident, and health

1 license who is designated as a chartered life underwriter (CLU);

2 (5) an applicant for a life and health insurance
3 counselor license who is designated as a chartered life underwriter
4 (CLU), chartered financial consultant (ChFC), or certified
5 financial planner (CFP);

6 (6) an applicant for a property and casualty license
7 who is designated as a chartered property casualty underwriter
8 (CPCU);

9 (7) an applicant for a specialty license issued under
10 Chapter 4055;

11 (8) a nonresident individual who is exempt from the
12 examination requirement under Chapter 4056; or

13 (9) an applicant for a general life, accident, and
14 health license who was authorized to solicit or procure insurance
15 on behalf of a fraternal benefit society on September 1, 1999, if
16 the applicant:

17 (A) solicited or procured insurance on behalf of
18 the fraternal benefit society for at least 24 months preceding
19 September 1, 1999; and

20 (B) does not, on or after September 1, 1999,
21 solicit or procure:

22 (i) insurance for any other insurer or a
23 different fraternal benefit society;

24 (ii) an insurance contract from anyone
25 other than a person who is eligible for membership in the fraternal
26 benefit society; or

27 (iii) an interest-sensitive life insurance

1 contract that exceeds \$35,000 of coverage on an individual life,
2 unless the applicant is designated as a "Fraternal Insurance
3 Counselor" at the time the contract is solicited or procured.

4 (b) A license to which the exemption authorized by
5 Subsection (a)(9) applies must be held by the applicant in an
6 individual capacity and is not transferable. (V.T.I.C. Art.
7 21.01-1, Secs. 2(d), (e).)

8 Sec. 4002.004. ADVISORY BOARD. (a) The commissioner may
9 appoint one or more advisory boards to make recommendations to the
10 commissioner or the testing service regarding:

11 (1) the scope, type, and conduct of examinations
12 required by this chapter; and

13 (2) the times and locations in this state where the
14 examinations shall be held.

15 (b) The commissioner may appoint to an advisory board any
16 combination of the following:

17 (1) a person who holds a license for which an
18 examination is intended;

19 (2) an employee of an insurer that appoints license
20 holders for which an examination is intended;

21 (3) a person who acts as a general agent or manager;

22 (4) a person who teaches insurance at an accredited
23 college or university in this state; or

24 (5) a resident of this state who is not described by
25 Subdivisions (1)-(4).

26 (c) A member of an advisory board serves without
27 compensation but is entitled to reimbursement for reasonable

1 expenses incurred in attending meetings of the advisory board.
2 (V.T.I.C. Art. 21.01-1, Sec. 1(b).)

3 Sec. 4002.005. EXAMINATION FEE. (a) The department shall
4 charge each applicant an examination fee in an amount determined by
5 the department as necessary to administer the examination.

6 (b) The examination fee must accompany each application to
7 take the examination.

8 (c) An applicant may receive a refund of the examination fee
9 only if:

10 (1) the applicant fails to take the examination
11 because of an emergency;

12 (2) the applicant notifies the department of the
13 emergency at least 24 hours before the time of the examination; and

14 (3) the department agrees to refund the fee.
15 (V.T.I.C. Art. 21.01-1, Sec. 2(b).)

16 Sec. 4002.006. BILINGUAL EXAMINATION. An examination
17 administered under this chapter shall be offered in English and
18 Spanish. (V.T.I.C. Art. 21.01-1, Sec. 2(f).)

19 Sec. 4002.007. EXAMINATION RESULTS. (a) The department
20 shall notify each examinee of the results of a licensing
21 examination administered under this code not later than the 30th
22 day after the date the examination is administered. If an
23 examination is graded or reviewed by a testing service, the
24 department shall notify each examinee of the results of the
25 examination not later than the 14th day after the date the
26 department receives the results from the testing service.

27 (b) The department may require a testing service to notify

examinees of the results of an examination.

(c) If the notice of the results of an examination graded or reviewed by a testing service will be delayed for longer than 90 days after the examination date, the department shall notify the examinee of the reason for the delay before the 90th day.

(d) If requested in writing by a person who fails a licensing examination administered under this code, the department shall provide to the person an analysis of the person's performance on the examination. (V.T.I.C. Art. 21.01-1, Secs. 1(d), (e).)

[Sections 4002.008-4002.050 reserved for expansion]

SUBCHAPTER B. ADMINISTRATION OF EXAMINATION BY

TESTING SERVICE

Sec. 4002.051. ADMINISTRATION BY TESTING SERVICE AUTHORIZED. The commissioner may accept an examination administered by a testing service to satisfy the examination requirements of a person seeking a license as an agent, counselor, or adjuster under this code. (V.T.I.C. Art. 21.01-1, Sec. 1(a) (part).)

Sec. 4002.052. AGREEMENT WITH TESTING SERVICE. (a) The commissioner may negotiate an agreement with a testing service to perform examination services, including:

- (1) developing an examination;
- (2) scheduling an examination;
- (3) arranging the site for an examination; and
- (4) administering, grading, reporting, and analyzing an examination.

(b) The commissioner may require a testing service to:

1 (1) correspond directly with applicants with regard to
2 the administration of examinations;

3 (2) collect fees for administering examinations
4 directly from applicants; and

5 (3) provide for the administration of examinations in
6 specific locations and at specified frequencies.

7 (c) The commissioner shall retain the authority to
8 establish the scope and type of each examination. (V.T.I.C. Art.
9 21.01-1, Sec. 1(a) (part).)

10 Sec. 4002.053. HEARING REQUIRED BEFORE AGREEMENT. Before
11 the department may negotiate and enter into an agreement with a
12 testing service:

13 (1) a hearing must be held in accordance with Chapter
14 2001, Government Code; and

15 (2) the commissioner must adopt any rules or standards
16 that the commissioner considers appropriate to implement the
17 authority granted by this chapter. (V.T.I.C. Art. 21.01-1, Sec.
18 1(a) (part).)

19 [Sections 4002.054-4002.100 reserved for expansion]

20 SUBCHAPTER C. DUTIES OF DEPARTMENT

21 Sec. 4002.101. ADMINISTRATION BY DEPARTMENT. In the
22 absence of an agreement with a testing service, the department
23 shall administer any required examination in accordance with this
24 chapter. (V.T.I.C. Art. 21.01-1, Sec. 1(c) (part).)

25 Sec. 4002.102. RULES. (a) The commissioner may adopt rules
26 relating to:

27 (1) the scope, type, and conduct of an examination;

1 (2) the time and location in this state at which an
2 examination is conducted; or

3 (3) the designation of textbooks, manuals, and other
4 materials to be studied by an applicant for an examination.

5 (b) The textbooks, manuals, or other materials designated
6 by the commissioner under Subsection (a)(3) may consist of:

7 (1) material available to an applicant by purchase
8 from the publisher; or

9 (2) material prepared at the direction of the
10 commissioner and distributed to an applicant on request and on
11 payment of the reasonable cost of the material. (V.T.I.C. Art.
12 21.01-1, Sec. 1(c) (part).)

13 Sec. 4002.103. CONTENT OF EXAMINATION QUESTIONS. All
14 examination questions must be prepared from the contents of the
15 textbooks, manuals, and other materials designated or prepared by
16 the commissioner under Section 4002.102. (V.T.I.C. Art. 21.01-1,
17 Sec. 1(c) (part).)

18 CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL

19 Sec. 4003.001. LICENSE EXPIRATION

20 Sec. 4003.002. STAGGERED RENEWAL SYSTEM

21 Sec. 4003.003. NOTICE OF LICENSE EXPIRATION

22 Sec. 4003.004. PROCEDURE FOR RENEWAL OF LICENSE

23 Sec. 4003.005. RENEWAL FEE NONREFUNDABLE

24 Sec. 4003.006. CONTINUATION OF ORIGINAL LICENSE

25 Sec. 4003.007. RENEWAL OF EXPIRED LICENSE

26 Sec. 4003.008. RENEWAL OF EXPIRED LICENSE BY

27 OUT-OF-STATE AGENT

1 Sec. 4003.009. INTERSTATE MOVE BY AGENT

2 Sec. 4003.010. CHAPTER NOT APPLICABLE TO THIRD-PARTY

3 ADMINISTRATORS

4 CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL

5 Sec. 4003.001. LICENSE EXPIRATION. (a) Unless a staggered
6 renewal system is adopted under Section 4003.002, each agent
7 license issued by the department and not suspended or revoked by the
8 commissioner expires on the second anniversary of the date the
9 license is issued.

10 (b) The commissioner by rule may change the two-year
11 expiration period if the commissioner determines that the change is
12 necessary to promote uniformity of license periods of this state
13 with those of other states. (V.T.I.C. Art. 21.01-2, Sec. 1A(a)
14 (part).)

15 Sec. 4003.002. STAGGERED RENEWAL SYSTEM. (a) The
16 commissioner by rule may adopt a system under which licenses expire
17 on various dates during a licensing period.

18 (b) For the licensing period in which the license expiration
19 is changed, license fees shall be prorated so that each license
20 holder pays only that portion of the license fee allocable to the
21 period during which the license is valid. On renewal of the license
22 on the new expiration date, the total renewal fee is payable.

23 (c) The commissioner shall adopt a system under which a
24 person who holds more than one license may renew all the licenses
25 held in a single process. (V.T.I.C. Art. 21.01-2, Sec. 1A(j).)

26 Sec. 4003.003. NOTICE OF LICENSE EXPIRATION. Not later
27 than the 30th day before the date a person's license expires, the

1 department shall send written notice of the impending license
2 expiration to the person at the person's last known mailing address
3 according to the department's records. (V.T.I.C. Art. 21.01-2,
4 Sec. 1A(i).)

5 Sec. 4003.004. PROCEDURE FOR RENEWAL OF LICENSE. (a) A
6 person may renew an unexpired license by:

7 (1) filing a properly completed renewal application
8 with the department in the form prescribed by the department; and

9 (2) paying to the department the required renewal fee
10 in an amount set by the department.

11 (b) A person may not renew a license that has been suspended
12 or revoked. (V.T.I.C. Art. 21.01-2, Secs. 1A(a) (part), (b)
13 (part).)

14 Sec. 4003.005. RENEWAL FEE NONREFUNDABLE. A renewal fee
15 paid under this chapter is nonrefundable. (V.T.I.C. Art. 21.01-2,
16 Sec. 1A(a) (part).)

17 Sec. 4003.006. CONTINUATION OF ORIGINAL LICENSE. The
18 original license of a person who has applied for license renewal in
19 compliance with Section 4003.004 remains in effect from the date
20 the renewal application is filed until the date:

21 (1) the department issues the renewal license; or

22 (2) the commissioner issues an order revoking the
23 license. (V.T.I.C. Art. 21.01-2, Sec. 1A(b) (part).)

24 Sec. 4003.007. RENEWAL OF EXPIRED LICENSE. (a) A person
25 whose license has been expired for 90 days or less may renew the
26 license by:

27 (1) filing a renewal application with the department

1 in the form prescribed by the department; and

2 (2) paying to the department:

3 (A) the required renewal fee; and

4 (B) an additional fee equal to one-half of the
5 required renewal fee.

6 (b) A person whose license has been expired for more than 90
7 days but less than one year may not renew the license. The person
8 may obtain a new license without taking the applicable examination
9 by:

10 (1) filing a new application with the department; and

11 (2) paying to the department:

12 (A) the license fee; and

13 (B) an additional fee equal to one-half of the
14 license fee.

15 (c) A person whose license has been expired for one year or
16 more may not renew the license. The person may obtain a new license
17 by:

18 (1) submitting to reexamination, if examination is
19 required for original issuance of the license; and

20 (2) complying with the other requirements and
21 procedures for obtaining an original license. (V.T.I.C. Art.
22 21.01-2, Secs. 1A(c), (d), (e).)

23 Sec. 4003.008. RENEWAL OF EXPIRED LICENSE BY OUT-OF-STATE
24 AGENT. (a) The department may renew without reexamination an
25 expired license of a person who was licensed in this state, moved to
26 another state, and is currently licensed and has been in continual
27 practice in the other state preceding the date of the application.

(b) The person must pay to the department a fee equal to the license fee. (V.T.I.C. Art. 21.01-2, Sec. 1A(f).)

Sec. 4003.009. INTERSTATE MOVE BY AGENT. (a) Not later than the 30th day after moving from one state to another state, an agent licensed in this state shall file with the department:

(1) the agent's new address; and

(2) proof of authorization to engage in the business of insurance in the new state of residence.

(b) The department may not charge a fee or require a license application under this section. (V.T.I.C. Art. 21.01-2, Secs. 1A(g), (h).)

Sec. 4003.010. CHAPTER NOT APPLICABLE TO THIRD-PARTY ADMINISTRATORS. This chapter does not apply to a certificate of authority issued under Chapter 4151. (V.T.I.C. Art. 21.01-2, Sec. 1A(k).)

CHAPTER 4004. CONTINUING EDUCATION

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4004.001. DEPARTMENT JURISDICTION EXCLUSIVE

Sec. 4004.002. ADVISORY COUNCIL

[Sections 4004.003-4004.050 reserved for expansion]

SUBCHAPTER B. AGENT CONTINUING EDUCATION REQUIREMENTS

Sec. 4004.051. GENERAL REQUIREMENTS

Sec. 4004.052. EXTENSIONS AND EXEMPTIONS

Sec. 4004.053. REQUIREMENTS BASED ON TYPE OF LICENSE HELD

Sec. 4004.054. ETHICS REQUIREMENT

[Sections 4004.055-4004.100 reserved for expansion]

SUBCHAPTER C. CONTINUING EDUCATION PROGRAMS

1 Sec. 4004.101. PROGRAM CERTIFICATION

2 Sec. 4004.102. CERTIFICATION FEE

3 Sec. 4004.103. PROVIDER REGISTRATION; OTHER REQUIREMENTS

4 Sec. 4004.104. INDEPENDENT CONTRACTORS

5 CHAPTER 4004. CONTINUING EDUCATION

6 SUBCHAPTER A. GENERAL PROVISIONS

7 Sec. 4004.001. DEPARTMENT JURISDICTION EXCLUSIVE. The
8 department has exclusive jurisdiction of all matters relating to
9 the continuing education of agents licensed under this code.
10 (V.T.I.C. Art. 21.01-1, Sec. 3(a).)

11 Sec. 4004.002. ADVISORY COUNCIL. (a) The commissioner may
12 appoint an advisory council to provide the commissioner with
13 information and assistance in the conduct of the continuing
14 education program for agents licensed under this title.

15 (b) If an advisory council is appointed, the council must be
16 composed of nine members, four of whom must be public members.

17 (c) A public member is entitled to reimbursement for the
18 member's travel expenses as provided by Chapter 660, Government
19 Code, and the General Appropriations Act.

20 (d) A public member may not:

21 (1) be an officer, director, or employee of an
22 insurer, insurance agency, agent, broker, adjuster, or other
23 business entity regulated by the department;

24 (2) be a person required to register with the Texas
25 Ethics Commission under Chapter 305, Government Code; or

26 (3) be related to a person described by Subdivision
27 (1) or (2) within the second degree by affinity or consanguinity, as

determined under Chapter 573, Government Code. (V.T.I.C. Art. 21.01-1, Sec. 3(g).)

[Sections 4004.003-4004.050 reserved for expansion]

SUBCHAPTER B. AGENT CONTINUING EDUCATION REQUIREMENTS

Sec. 4004.051. GENERAL REQUIREMENTS. (a) Except as provided by Section 4004.052 or other law, each individual who holds a license issued by the department shall complete continuing education as provided by this chapter.

(b) All required continuing education hours must be completed before the expiration date of the individual's license.

(c) At least 50 percent of all required continuing education hours must be completed in a classroom setting or a classroom equivalent setting approved by the department.

(d) The department may accept continuing education hours completed in other professions or in association with professional designations in an insurance-related field. (V.T.I.C. Art. 21.01-1, Sec. 3(b) (part).)

Sec. 4004.052. EXTENSIONS AND EXEMPTIONS. (a) On the timely written request of an agent, the department may extend the time for the agent to comply with the continuing education requirements of this chapter or may exempt the agent from some or all of the requirements for a licensing period if the department determines that the agent is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the agent. The commissioner by rule shall prescribe the criteria for an exemption or extension under this subsection.

1 (b) An individual who has continuously held for at least 20
2 years an agent license issued under this code is exempt from the
3 continuing education requirements of this chapter.

4 (c) The commissioner by rule may provide for other
5 reasonable exemptions from the continuing education requirements
6 of this chapter. (V.T.I.C. Art. 21.01-1, Secs. 3(c), (d).)

7 Sec. 4004.053. REQUIREMENTS BASED ON TYPE OF LICENSE HELD.

8 (a) An individual who holds a general life, accident, and health
9 license, a life and health insurance counselor license, or a
10 general property and casualty license must complete 15 hours of
11 continuing education annually. If the individual holds more than
12 one license for which continuing education is otherwise required,
13 the individual is not required to complete more than 15 continuing
14 education hours annually.

15 (b) An individual who holds a limited life, accident, and
16 health license or a limited property and casualty license must
17 complete five hours of continuing education annually. (V.T.I.C.
18 Art. 21.01-1, Sec. 3(b) (part).)

19 Sec. 4004.054. ETHICS REQUIREMENT. Each individual who
20 holds a license issued by the department shall complete two hours of
21 continuing education in ethics during each license renewal period.
22 (V.T.I.C. Art. 21.01-1, Sec. 3(b) (part).)

23 [Sections 4004.055-4004.100 reserved for expansion]

24 SUBCHAPTER C. CONTINUING EDUCATION PROGRAMS

25 Sec. 4004.101. PROGRAM CERTIFICATION. (a) The department
26 shall certify continuing education programs for agents. The
27 certification criteria must be designed to ensure that continuing

1 education programs enhance the knowledge, understanding, and
2 professional competence of the license holder.

3 (b) Only a program that satisfies the criteria established
4 by rule by the commissioner may receive certification. (V.T.I.C.
5 Art. 21.01-1, Sec. 3(e) (part).)

6 Sec. 4004.102. CERTIFICATION FEE. (a) A nonrefundable
7 certification fee, in an amount set by the commissioner as
8 necessary to administer this chapter, must accompany each
9 application for certification of a continuing education program.

10 (b) The commissioner by rule shall establish the
11 certification fee based on a graduated scale according to the
12 number of hours required to complete the program. (V.T.I.C. Art.
13 21.01-1, Sec. 3(e) (part).)

14 Sec. 4004.103. PROVIDER REGISTRATION; OTHER REQUIREMENTS.

15 (a) Each continuing education program provider shall register with
16 the department as a course provider.

17 (b) The department shall assess a registration fee for each
18 application for registration as a course provider, set by the
19 commissioner in an amount necessary for the proper administration
20 of this chapter.

21 (c) The commissioner may adopt rules establishing other
22 requirements for continuing education program providers.
23 (V.T.I.C. Art. 21.01-1, Sec. 3(f) (part).)

24 Sec. 4004.104. INDEPENDENT CONTRACTORS. (a) The
25 department may enter into agreements with independent contractors
26 under which the independent contractor certifies and registers
27 continuing education programs and providers.

(b) The department may require the independent contractors to correspond directly with providers with regard to the administration of continuing education programs. The contractors may collect fees from the providers for administration of the courses.

(c) Notwithstanding Subsections (a) and (b), the department retains the authority to establish the scope and type of continuing education requirements for each type of license. (V.T.I.C. Art. 21.01-1, Sec. 3(f) (part).)

CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND
SANCTIONS

SUBCHAPTER A. AUTHORIZED CONDUCT

Sec. 4005.001. DEFINITION

Sec. 4005.002. AUTHORIZATION TO OBTAIN CERTAIN RECORDS OR
PHOTOGRAPHS

Sec. 4005.003. FEES

[Sections 4005.004-4005.050 reserved for expansion]

SUBCHAPTER B. PROHIBITED CONDUCT

Sec. 4005.051. APPLICABILITY OF SUBCHAPTER

Sec. 4005.052. CERTAIN CONDUCT PROHIBITED AFTER REVOCATION
OF LICENSE

Sec. 4005.053. CERTAIN PAYMENTS PROHIBITED TO OR FROM
PERSON NOT HOLDING LICENSE

Sec. 4005.054. RECEIVING ADDITIONAL FEE PROHIBITED

Sec. 4005.055. CERTAIN COVERAGE FOR LOSS BY FIRE
PROHIBITED

[Sections 4005.056-4005.100 reserved for expansion]

SUBCHAPTER C. DISCIPLINARY ACTIONS AND PROCEDURES;
ENFORCEMENT

Sec. 4005.101. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
ACTION

Sec. 4005.102. REMEDIES FOR VIOLATION OF INSURANCE LAWS
OR COMMISSIONER RULES

Sec. 4005.103. PROBATED LICENSE SUSPENSION

Sec. 4005.104. HEARING

Sec. 4005.105. APPLICATION FOR LICENSE AFTER DENIAL OF
APPLICATION OR REVOCATION OF LICENSE

Sec. 4005.106. APPLICATION FOR LICENSE AFTER CERTAIN
DETERMINATIONS

Sec. 4005.107. DISCIPLINARY PROCEEDING FOR CONDUCT COMMITTED
BEFORE SURRENDER OR FORFEITURE OF
LICENSE

Sec. 4005.108. DISABILITY PROBATION

Sec. 4005.109. FINES

Sec. 4005.110. ENFORCEMENT OF TITLE

[Sections 4005.111-4005.150 reserved for expansion]

SUBCHAPTER D. CRIMINAL PENALTIES

Sec. 4005.151. ACTING AS AGENT AFTER LICENSE SUSPENSION OR
REVOCATION; CRIMINAL PENALTY

Sec. 4005.152. AGENT ASSISTING OR CONSPIRING WITH PERSON
WHOSE LICENSE HAS BEEN SUSPENDED OR
REVOKED; CRIMINAL PENALTY

Sec. 4005.153. EMBEZZLEMENT OR CONVERSION BY AGENT; CRIMINAL
PENALTY

CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND

SANCTIONS

SUBCHAPTER A. AUTHORIZED CONDUCT

Sec. 4005.001. DEFINITION. In this subchapter, "client" means:

- (1) an applicant for insurance coverage; or
- (2) an insured. (V.T.I.C. Art. 21.35A, Sec. (a).)

Sec. 4005.002. AUTHORIZATION TO OBTAIN CERTAIN RECORDS OR PHOTOGRAPHS. (a) In connection with a client's application for insurance coverage, the issuance of an insurance policy to a client, or on a client's request, a general property and casualty agent may obtain:

- (1) the motor vehicle record of a person insured under or to be insured under an insurance policy; or
- (2) a photograph of property insured under or to be insured under an insurance policy.

(b) The agent must provide a copy of the motor vehicle record to the client. (V.T.I.C. Art. 21.35A, Sec. (b) (part).)

Sec. 4005.003. FEES. (a) A general property and casualty agent may charge a client a fee to reimburse the agent for costs the agent incurred in obtaining a motor vehicle record or photograph of property described under Section 4005.002. The fee may not exceed the actual costs to the agent.

(b) For services provided to a client, a general property and casualty agent may charge a reasonable fee, including a fee for:

- (1) special delivery or postal charges;
- (2) printing or reproduction costs;

1 (3) electronic mail costs;
2 (4) telephone transmission costs; and
3 (5) similar costs that the agent incurs on behalf of
4 the client.

5 (c) A general property and casualty agent may charge a
6 client a fee under this section only if, before the agent incurs an
7 expense for the client, the agent:

8 (1) notifies the client of the agent's fee; and
9 (2) obtains the client's written consent for each fee
10 to be charged. (V.T.I.C. Art. 21.35A, Secs. (b) (part), (c), (d).)

11 [Sections 4005.004-4005.050 reserved for expansion]

12 SUBCHAPTER B. PROHIBITED CONDUCT

13 Sec. 4005.051. APPLICABILITY OF SUBCHAPTER. This
14 subchapter does not apply to a person who holds a license or
15 certificate of authority issued under Title 11. (V.T.I.C. Art.
16 21.01-2, Sec. 2A(i).)

17 Sec. 4005.052. CERTAIN CONDUCT PROHIBITED AFTER REVOCATION
18 OF LICENSE. A person whose insurance license has been revoked in
19 this state or any other state may not:

20 (1) solicit or otherwise engage in business under
21 Chapter 885 unless the department determines it to be in the public
22 interest, for good cause shown, to permit the person to act in that
23 capacity; or

24 (2) act as an officer, director, member, manager, or
25 partner, or as a shareholder with a controlling interest, of an
26 entity holding a license issued under this title unless the
27 department determines it to be in the public interest, for good

1 cause shown, to permit the person to act in that capacity.
2 (V.T.I.C. Art. 21.01-2, Secs. 2A(e), (f).)

3 Sec. 4005.053. CERTAIN PAYMENTS PROHIBITED TO OR FROM
4 PERSON NOT HOLDING LICENSE. (a) An insurer or agent engaged in the
5 business of insurance in this state may not pay to any person,
6 directly or indirectly, and may not accept from any person a
7 commission or other valuable consideration for a service performed
8 by that person as an agent in this state unless the person holds a
9 license to act as an agent in this state.

10 (b) Subsection (a) does not prevent the payment of a renewal
11 or other deferred commission to a person or the acceptance of a
12 renewal or other deferred compensation by a person solely because
13 the person no longer holds a license to act as an agent.

14 (c) An agent may not pay, permit, or give or offer to pay,
15 permit, or give, directly or indirectly, to any person who does not
16 hold a license as an agent:

17 (1) a rebate of premiums payable, a commission,
18 employment, a contract for service, or any other valuable
19 consideration or inducement that is not specified in the insurance
20 policy or contract for or on account of the solicitation or
21 negotiation of an insurance contract; or

22 (2) a fee or other valuable consideration for
23 referring a customer who seeks to purchase an insurance product or
24 seeks an opinion on or advice regarding an insurance product, based
25 on that customer's purchase of insurance. (V.T.I.C. Art. 21.01-2,
26 Secs. 2A(b), (c), (h).)

27 Sec. 4005.054. RECEIVING ADDITIONAL FEE PROHIBITED. A

1 person who holds a license under this code and receives a commission
2 or other consideration for services as an agent may not receive an
3 additional fee for those services provided to the same client
4 except for a fee described by Section 550.001 or 4005.003.
5 (V.T.I.C. Art. 21.01-2, Sec. 2A(a).)

6 Sec. 4005.055. CERTAIN COVERAGE FOR LOSS BY FIRE
7 PROHIBITED. A property and casualty agent may not knowingly grant,
8 write, or permit a greater amount of insurance against loss by fire
9 than the reasonable value of the insured subject. (V.T.I.C. Art.
10 21.01-2, Sec. 2A(g).)

11 [Sections 4005.056-4005.100 reserved for expansion]

12 SUBCHAPTER C. DISCIPLINARY ACTIONS AND PROCEDURES;
13 ENFORCEMENT

14 Sec. 4005.101. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
15 ACTION. (a) This section does not apply to a person who holds a
16 license or certificate of authority issued under Title 11.

17 (b) The department may deny a license application or
18 discipline a license holder under this subchapter if the department
19 determines that the applicant or license holder, individually or
20 through an officer, director, or shareholder:

21 (1) has wilfully violated an insurance law of this
22 state;

23 (2) has intentionally made a material misstatement in
24 the license application;

25 (3) has obtained or attempted to obtain a license by
26 fraud or misrepresentation;

27 (4) has misappropriated, converted to the applicant's

1 or license holder's own use, or illegally withheld money belonging
2 to:

3 (A) an insurer;

4 (B) a health maintenance organization; or

5 (C) an insured, enrollee, or beneficiary;

6 (5) has engaged in fraudulent or dishonest acts or
7 practices;

8 (6) has materially misrepresented the terms and
9 conditions of an insurance policy or contract, including a contract
10 relating to membership in a health maintenance organization;

11 (7) has made or issued, or caused to be made or issued,
12 a statement misrepresenting or making incomplete comparisons
13 regarding the terms or conditions of an insurance or annuity
14 contract legally issued by an insurer or a membership issued by a
15 health maintenance organization to induce the owner of the contract
16 or membership to forfeit or surrender the contract or membership or
17 allow it to lapse for the purpose of replacing the contract or
18 membership with another;

19 (8) has been convicted of a felony;

20 (9) has offered or given a rebate of an insurance
21 premium or commission to an insured or enrollee;

22 (10) is not actively engaged in soliciting or writing
23 insurance for the public generally as required by Section
24 4001.104(a); or

25 (11) has obtained or attempted to obtain a license,
26 not for the purpose of holding the applicant or license holder out
27 to the general public as an agent, but primarily for the purpose of

1 soliciting, negotiating, or procuring an insurance or annuity
2 contract or membership covering:

- 3 (A) the applicant or license holder;
- 4 (B) a member of the applicant's or license
5 holder's family; or
- 6 (C) a business associate of the applicant or
7 license holder. (V.T.I.C. Art. 21.01-2, Secs. 3A(c), (h).)

8 Sec. 4005.102. REMEDIES FOR VIOLATION OF INSURANCE LAWS OR
9 COMMISSIONER RULES. In addition to any other remedy available
10 under Chapter 82, for a violation of this code, another insurance
11 law of this state, or a rule of the commissioner, the department
12 may:

- 13 (1) deny an application for an original license;
- 14 (2) suspend, revoke, or deny renewal of a license;
- 15 (3) place on probation a person whose license has been
16 suspended;
- 17 (4) assess an administrative penalty; or
- 18 (5) reprimand a license holder. (V.T.I.C. Art.
19 21.01-2, Sec. 3A(a) (part).)

20 Sec. 4005.103. PROBATED LICENSE SUSPENSION. If a license
21 suspension is probated, the commissioner may require the license
22 holder to:

- 23 (1) report regularly to the department on any matter
24 that is the basis of the probation;
- 25 (2) limit the license holder's practice to the areas
26 prescribed by the department; or
- 27 (3) continue or review professional education until

1 the license holder attains a degree of skill satisfactory to the
2 commissioner in each area that is the basis of the probation.
3 (V.T.I.C. Art. 21.01-2, Sec. 3A(a) (part).)

4 Sec. 4005.104. HEARING. (a) If the department proposes to
5 deny an application for an original license or to suspend, revoke,
6 or deny renewal of a license, the applicant or license holder is
7 entitled to a hearing conducted by the State Office of
8 Administrative Hearings as provided by Chapter 40.

9 (b) Notice of the hearing shall be provided to:

10 (1) the applicant or license holder; and

11 (2) any insurer indicated on the application as
12 desiring that the license be issued. (V.T.I.C. Art. 21.01-2, Sec.
13 3A(b).)

14 Sec. 4005.105. APPLICATION FOR LICENSE AFTER DENIAL OF
15 APPLICATION OR REVOCATION OF LICENSE. (a) This section does not
16 apply to a person who holds a license or certificate of authority
17 issued under Title 11.

18 (b) An individual whose license application has been denied
19 or whose license has been revoked under this subchapter may not
20 apply for an agent license before the fifth anniversary of:

21 (1) the effective date of the denial or revocation; or

22 (2) the date of a final court order affirming the
23 denial or revocation if judicial review was sought.

24 (c) A license application filed after the time required by
25 Subsection (b) may be denied by the commissioner if the applicant
26 fails to show good cause why the denial or revocation should not be
27 a bar to the issuance of a new license.

1 (d) Subsection (c) does not apply to an applicant whose
2 license application was denied for failure by the applicant to:

- 3 (1) pass a required written examination; or
4 (2) submit a properly completed license application.
5 (V.T.I.C. Art. 21.01-2, Secs. 3A(d), (e), (h).)

6 Sec. 4005.106. APPLICATION FOR LICENSE AFTER CERTAIN
7 DETERMINATIONS. (a) In addition to any other penalty imposed under
8 this code, a person who the department determines has engaged in
9 conduct described by this section may not obtain a license as an
10 agent before the fifth anniversary of the date of the
11 determination.

12 (b) This section applies to a person who:

13 (1) acts as an agent without holding a license under
14 this code;

15 (2) solicits an insurance contract or acts as an agent
16 without having been appointed or designated by an authorized
17 insurer, association, or organization to do so as provided by this
18 code;

19 (3) solicits an insurance contract or acts as an agent
20 for a person, including an insurer, association, or organization,
21 who is not authorized to engage in the business of insurance in this
22 state without holding a surplus lines agent license issued under
23 Chapter 981; or

24 (4) as an officer or representative of an insurer,
25 knowingly contracts with or appoints as an agent a person who does
26 not hold a valid license. (V.T.I.C. Art. 21.01-2, Sec. 2A(d).)

27 Sec. 4005.107. DISCIPLINARY PROCEEDING FOR CONDUCT

1 COMMITTED BEFORE SURRENDER OR FORFEITURE OF LICENSE. (a) The
2 department may institute a disciplinary proceeding against a former
3 license holder for conduct committed before the effective date of a
4 voluntary surrender or automatic forfeiture of the license.

5 (b) In a proceeding under this section, the fact that the
6 license holder has surrendered or forfeited the license does not
7 affect the former license holder's culpability for the conduct that
8 is the subject of the proceeding. (V.T.I.C. Art. 21.01-2, Sec.
9 3A(g).)

10 Sec. 4005.108. DISABILITY PROBATION. (a) This section
11 does not apply to a person who holds a license or certificate of
12 authority issued under Title 11.

13 (b) Instead of or in addition to taking disciplinary action
14 under Section 4005.102, 4005.103, 4005.105(c), or 4005.107, the
15 department may order that a license holder who is disabled be placed
16 on disability probation under the terms specified under Chapter
17 4006 and department rules. (V.T.I.C. Art. 21.01-2, Secs. 3A(f),
18 (h).)

19 Sec. 4005.109. FINES. (a) To expedite the department's
20 processing of certain violations of this code, the commissioner by
21 rule may establish fines for certain violations.

22 (b) A violation for which a fine may be assessed under this
23 section includes a failure to:

24 (1) obtain the total number of continuing education
25 hours before the renewal date of a license;

26 (2) timely report a change of address to the
27 department; or

1 (3) notify the department of an administrative action
2 against the agent by a financial or insurance regulator of another
3 state or of the federal government.

4 (c) This section does not limit the department's authority
5 to take any other disciplinary action against a license holder as
6 otherwise provided by this code.

7 (d) The dispute of an assessment of a fine under this
8 section is a contested case subject to Chapter 2001, Government
9 Code. (V.T.I.C. Art. 21.01-2, Sec. 5A.)

10 Sec. 4005.110. ENFORCEMENT OF TITLE. The attorney general,
11 a district or county attorney, or the department acting through the
12 commissioner may bring a proceeding for an injunction or bring any
13 other proceeding to enforce this title and to enjoin any person,
14 firm, corporation, or depository institution from engaging in or
15 attempting to engage in the business of insurance in violation of
16 this code or any other insurance law of this state. (V.T.I.C. Art.
17 21.01-2, Sec. 6A (part).)

18 [Sections 4005.111-4005.150 reserved for expansion]

19 SUBCHAPTER D. CRIMINAL PENALTIES

20 Sec. 4005.151. ACTING AS AGENT AFTER LICENSE SUSPENSION OR
21 REVOCATION; CRIMINAL PENALTY. (a) A person commits an offense if
22 the person acts as an agent after the person's agent license has
23 been suspended or revoked.

24 (b) An offense under this section is a felony punishable by:
25 (1) a fine not to exceed \$5,000;
26 (2) imprisonment for a term of not more than two years;
27 or

1 (3) both fine and imprisonment under this subsection.
2 (V.T.I.C. Art. 21.15-1, Sec. 1.)

3 Sec. 4005.152. AGENT ASSISTING OR CONSPIRING WITH PERSON
4 WHOSE LICENSE HAS BEEN SUSPENDED OR REVOKED; CRIMINAL PENALTY. (a)
5 A person commits an offense if the person is an agent who holds a
6 license under this code and the person assists or conspires with a
7 person whose license as an agent has been suspended or revoked to
8 act as an agent.

9 (b) An offense under this section is a misdemeanor
10 punishable by:

11 (1) a fine not to exceed \$1,000;

12 (2) confinement in jail for a term of not more than six
13 months; or

14 (3) both fine and confinement in jail under this
15 subsection. (V.T.I.C. Art. 21.15-1, Sec. 2.)

16 Sec. 4005.153. EMBEZZLEMENT OR CONVERSION BY AGENT;
17 CRIMINAL PENALTY. (a) A person commits an offense if the person,
18 as an agent for an insurer lawfully engaged in the business of
19 insurance in this state, collects premiums or otherwise receives
20 money or a substitute for money, and the person:

21 (1) embezzles, fraudulently converts, or appropriates
22 to the person's own use the money or substitute for money; or

23 (2) with intent to embezzle and contrary to the
24 instructions of or without the consent of the insurer, takes,
25 secretes, or otherwise disposes of or fraudulently withholds,
26 appropriates, lends, invests, or otherwise uses or applies, any
27 money or substitute for money received by the person in the person's

1 capacity as agent or broker.

2 (b) A person who commits an offense under this section shall
3 be punished as if the person had stolen the money or substitute for
4 money. (V.T.I.C. Art. 21.15-5.)

5 CHAPTER 4006. DISABILITY PROBATION OF AGENTS

6 SUBCHAPTER A. GENERAL PROVISIONS

7 Sec. 4006.001. DEFINITION

8 Sec. 4006.002. RULES

9 [Sections 4006.003-4006.050 reserved for expansion]

10 SUBCHAPTER B. POWERS AND DUTIES OF DEPARTMENT

11 Sec. 4006.051. DISABILITY PROBATION ORDER

12 Sec. 4006.052. RESTITUTION

13 Sec. 4006.053. DURATION OF PROBATION

14 Sec. 4006.054. PROBATION CONDITIONS

15 Sec. 4006.055. SUPERVISION DURING PROBATION

16 Sec. 4006.056. EFFECT OF NONCOMPLIANCE

17 CHAPTER 4006. DISABILITY PROBATION OF AGENTS

18 SUBCHAPTER A. GENERAL PROVISIONS

19 Sec. 4006.001. DEFINITION. In this chapter, "disability"
20 means any physical, mental, or emotional condition that results in
21 an agent's inability to carry out the agent's professional
22 responsibilities to insureds, the profession, or the public.
23 (V.T.I.C. Art. 21.15-6, Sec. (a) (part).)

24 Sec. 4006.002. RULES. The commissioner may adopt rules as
25 necessary to implement this chapter. (V.T.I.C. Art. 21.15-6, Sec.
26 (g).)

27 [Sections 4006.003-4006.050 reserved for expansion]

SUBCHAPTER B. POWERS AND DUTIES OF DEPARTMENT

Sec. 4006.051. DISABILITY PROBATION ORDER. (a) The department may order that an agent be placed on disability probation if, after notice and an opportunity for a hearing, the department determines that the agent is suffering from a disability.

(b) The department may order disability probation for an agent only if the agent demonstrates that:

(1) the disability can be successfully arrested and treated while the agent is engaged in the agent's professional business;

(2) the disability is unlikely to cause harm to the public during the period of rehabilitation;

(3) adequate supervision of any necessary conditions of the probation will occur; and

(4) the agent is capable of competently performing the agent's professional duties. (V.T.I.C. Art. 21.15-6, Secs. (a) (part), (b).)

Sec. 4006.052. RESTITUTION. (a) The department may order disability probation for an agent only if the agent makes full restitution during the probation period to all insureds and other persons harmed by the agent's:

(1) violation of this code or other laws regulating the business of insurance in this state; or

(2) failure to comply with other professional responsibilities.

(b) The department shall require the restitution described

1 by Subsection (a) as a condition of the probation. (V.T.I.C. Art.
2 21.15-6, Sec. (e).)

3 Sec. 4006.053. DURATION OF PROBATION. (a) If the
4 department orders disability probation, the department shall set
5 the probation for a specified period or until further order of the
6 department.

7 (b) The department may order a probation period that exceeds
8 the one-year maximum suspension authorized under Section
9 82.052(1). (V.T.I.C. Art. 21.15-6, Sec. (c).)

10 Sec. 4006.054. PROBATION CONDITIONS. (a) An order placing
11 an agent on disability probation must state the probation
12 conditions.

13 (b) In establishing the probation conditions, the
14 department shall consider:

15 (1) the nature and circumstances of the agent's
16 conduct;

17 (2) the agent's history, character, and condition; and

18 (3) the nature of the agent's disability.

19 (c) The department may impose on the agent any of the
20 following probation conditions:

21 (1) periodic reports to the department;

22 (2) satisfactory completion of a course of study
23 required by the department;

24 (3) payment of costs, including reasonable attorney's
25 fees and other expenses, related to the proceedings before the
26 department;

27 (4) psychological evaluation, counseling, and

1 treatment;

2 (5) drug and alcohol abuse evaluation, counseling, and
3 treatment;

4 (6) abstinence from alcohol or drugs;

5 (7) mandatory attendance at meetings of Alcoholics
6 Anonymous, Narcotics Anonymous, or similar support groups;

7 (8) periodic random urine testing to screen for drug
8 and alcohol abuse; and

9 (9) any other probation condition that the department
10 considers appropriate. (V.T.I.C. Art. 21.15-6, Sec. (d).)

11 Sec. 4006.055. SUPERVISION DURING PROBATION. The
12 department shall supervise an agent placed on disability probation.
13 (V.T.I.C. Art. 21.15-6, Sec. (f) (part).)

14 Sec. 4006.056. EFFECT OF NONCOMPLIANCE. On a showing of an
15 agent's failure to comply with the disability probation conditions,
16 the department may:

17 (1) revoke the probation; or

18 (2) impose other conditions that the department
19 considers necessary for the public's protection and the agent's
20 rehabilitation. (V.T.I.C. Art. 21.15-6, Sec. (f) (part).)

21 [Chapters 4007-4050 reserved for expansion]

22 SUBTITLE B. AGENTS

23 CHAPTER 4051. PROPERTY AND CASUALTY AGENTS

24 SUBCHAPTER A. GENERAL PROVISIONS

25 Sec. 4051.001. APPLICABILITY OF CHAPTER

26 Sec. 4051.002. REQUIREMENTS APPLICABLE TO CERTAIN AGENT

27 CONTRACTS

[Sections 4051.003-4051.050 reserved for expansion]

SUBCHAPTER B. GENERAL PROPERTY AND CASUALTY LICENSE

Sec. 4051.051. LICENSE REQUIRED

Sec. 4051.052. AUTHORITY TO WRITE ADDITIONAL LINES

Sec. 4051.053. AUTHORITY TO WRITE CERTAIN ACCIDENT

AND HEALTH INSURANCE

Sec. 4051.054. DECEASED, DISABLED, OR INSOLVENT AGENTS;

EMERGENCY LICENSE

[Sections 4051.055-4051.100 reserved for expansion]

SUBCHAPTER C. LIMITED PROPERTY AND CASUALTY LICENSE

Sec. 4051.101. LICENSE REQUIRED

Sec. 4051.102. DESIGNATION OF KINDS OF INSURANCE

[Sections 4051.103-4051.150 reserved for expansion]

SUBCHAPTER D. INSURANCE SERVICE REPRESENTATIVE LICENSE

Sec. 4051.151. LICENSE REQUIRED

Sec. 4051.152. APPLICABILITY OF CERTAIN REQUIREMENTS

[Sections 4051.153-4051.200 reserved for expansion]

SUBCHAPTER E. COUNTY MUTUAL AGENT LICENSE

Sec. 4051.201. LICENSE ISSUANCE

Sec. 4051.202. COURSE

Sec. 4051.203. EXAMINATION

Sec. 4051.204. INVESTIGATION BY DEPARTMENT

Sec. 4051.205. WITHDRAWAL OF COMPANY'S AUTHORITY

Sec. 4051.206. APPLICABILITY OF LIMITED LICENSE LAWS

[Sections 4051.207-4051.250 reserved for expansion]

SUBCHAPTER F. AGRICULTURAL INSURANCE AGENT

Sec. 4051.251. APPOINTMENT OF AGENT

1 Sec. 4051.252. REQUIREMENTS FOR APPOINTMENT; PROCEDURE

2 Sec. 4051.253. ACCEPTANCE OF CERTAIN CONTINUING EDUCATION

3 Sec. 4051.254. RULES

4 [Sections 4051.255-4051.300 reserved for expansion]

5 SUBCHAPTER G. REGISTRATION OF HOME OFFICE EMPLOYEES

6 Sec. 4051.301. REGISTRATION AND DISCLOSURE REQUIRED; FEE

7 Sec. 4051.302. CONTINUING EDUCATION REQUIREMENTS

8 Sec. 4051.303. SUSPENSION OF REGISTERED EMPLOYEE;

9 DISCIPLINARY ACTION AGAINST INSURER

10 [Sections 4051.304-4051.350 reserved for expansion]

11 SUBCHAPTER H. TERMINATION OR SUSPENSION OF AGENT

12 CONTRACTS BY PROPERTY AND CASUALTY INSURERS

13 Sec. 4051.351. APPLICABILITY OF SUBCHAPTER

14 Sec. 4051.352. SUSPENSION OF AGENT'S CONTRACT;

15 OTHER DEFINITIONS

16 Sec. 4051.353. NOTICE REQUIRED BEFORE TERMINATION OR

17 SUSPENSION OF CONTRACT

18 Sec. 4051.354. AUTOMATIC TERMINATION OF CONTRACT ON

19 WITHDRAWAL FROM STATE OR REDUCTION OF

20 BUSINESS

21 Sec. 4051.355. RENEWAL OF INSURANCE CONTRACTS AFTER

22 NOTICE OF TERMINATION OR SUSPENSION

23 Sec. 4051.356. INSURER REFUSAL TO RENEW AGENT'S BUSINESS

24 PROHIBITED

25 Sec. 4051.357. INSURER APPROVAL FOR NEW BUSINESS OR

26 INCREASE IN LIABILITY

27 Sec. 4051.358. PROVISION OF UNDERWRITING STANDARDS TO

AGENT WHOSE CONTRACT IS TERMINATED

OR SUSPENDED

Sec. 4051.359. PAYMENT OF MONEY DUE INSURER

Sec. 4051.360. REVISION OF TERMINATION PROVISIONS OF
AGENT'S CONTRACT

Sec. 4051.361. ADMINISTRATIVE PENALTY

Sec. 4051.362. ACTION FOR DAMAGES

CHAPTER 4051. PROPERTY AND CASUALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4051.001. APPLICABILITY OF CHAPTER. (a) This subchapter and Subchapters B-E and G apply to each agent of an insurer authorized to engage in the business of property and casualty insurance in this state.

(b) This subchapter and Subchapters B-E and G apply to each person who performs the acts of an agent, as described by Section 4001.051, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, procuring, or collecting a premium on an insurance contract offered by any kind of insurer authorized to engage in the business of property and casualty insurance in this state, including:

(1) a fidelity or surety company;

(2) a mutual insurance company, including a farm mutual or a county mutual;

(3) a reciprocal or interinsurance exchange; and

(4) a Lloyd's plan. (V.T.I.C. Art. 21.14, Sec. 1(b).)

Sec. 4051.002. REQUIREMENTS APPLICABLE TO CERTAIN AGENT CONTRACTS. An agent's contract entered into on or after August 27,

1 1973, by an insurer engaged in the business of property and casualty
2 insurance in this state is subject to Article 21.11-2. (New.)

3 [Sections 4051.003-4051.050 reserved for expansion]

4 SUBCHAPTER B. GENERAL PROPERTY AND CASUALTY LICENSE

5 Sec. 4051.051. LICENSE REQUIRED. A person is required to
6 hold a general property and casualty license if the person acts as:

7 (1) an agent who writes property and casualty
8 insurance for an insurer authorized to engage in the business of
9 property and casualty insurance in this state;

10 (2) a subagent of a person who holds a license as an
11 agent under this chapter who solicits and binds insurance risks for
12 that agent; or

13 (3) an agent who writes any other kind of insurance as
14 required by the commissioner for the protection of the insurance
15 consumers of this state. (V.T.I.C. Art. 21.14, Sec. 2.)

16 Sec. 4051.052. AUTHORITY TO WRITE ADDITIONAL LINES. A
17 person who holds a general property and casualty license may, in
18 addition, write the kinds of insurance contracts described by:

19 (1) Section 4051.101 and Subchapter E; or

20 (2) Chapter 4055. (V.T.I.C. Art. 21.14, Sec. 3.)

21 Sec. 4051.053. AUTHORITY TO WRITE CERTAIN ACCIDENT AND
22 HEALTH INSURANCE. A person who holds a general property and
23 casualty license may, without holding a license under Chapter 4054,
24 write health and accident insurance for a property and casualty
25 insurer authorized to sell those insurance products in this state.
26 (V.T.I.C. Art. 21.14, Sec. 4.)

27 Sec. 4051.054. DECEASED, DISABLED, OR INSOLVENT AGENTS;

1 EMERGENCY LICENSE. (a) If a property and casualty agent dies,
2 becomes disabled, or is found to be insolvent and unable to pay for
3 premiums as they become due to an insurer, the department may issue,
4 without examination, to an applicant for a property and casualty
5 agent license an emergency license on receipt of proof satisfactory
6 to the department that the emergency license is necessary to
7 preserve the agency assets of the deceased, disabled, or insolvent
8 agent.

9 (b) An emergency license is valid for 90 days in any 12
10 consecutive months and may be renewed by the department for an
11 additional 90 days during the 12-month period if the other
12 requirements of Subtitle A are satisfied. (V.T.I.C. Art. 21.14,
13 Sec. 5.)

14 [Sections 4051.055-4051.100 reserved for expansion]

15 SUBCHAPTER C. LIMITED PROPERTY AND CASUALTY LICENSE

16 Sec. 4051.101. LICENSE REQUIRED. (a) Except as provided by
17 Section 4051.052, a person is required to hold a limited property
18 and casualty license if the person acts as an agent who writes:

19 (1) job protection insurance as defined by Article
20 25.01;

21 (2) exclusively, insurance on growing crops under
22 Subchapter F;

23 (3) any form of insurance authorized under Chapter 911
24 for a farm mutual insurance company;

25 (4) exclusively, any form of insurance authorized to
26 be solicited and written in this state that relates to:

27 (A) the ownership, operation, maintenance, or

1 use of a motor vehicle designed for use on the public highways,
2 including a trailer or semitrailer, and the motor vehicle's
3 accessories or equipment; or

4 (B) the ownership, occupancy, maintenance, or
5 use of a manufactured home classified as personal property under
6 Section 2.001, Property Code;

7 (5) a prepaid legal services contract under Article
8 5.13-1 or Chapter 961;

9 (6) exclusively, an industrial fire insurance policy:

10 (A) covering dwellings, household goods, and
11 wearing apparel;

12 (B) written on a weekly, monthly, or quarterly
13 basis on a continuous premium payment plan; and

14 (C) written for an insurer exclusively engaged in
15 the business as described by Section 912.310;

16 (7) credit insurance, except as otherwise provided by
17 Chapter 4055; or

18 (8) any other kind of insurance, if holding a limited
19 property and casualty license to write that kind of insurance is
20 determined necessary by the commissioner for the protection of the
21 insurance consumers of this state.

22 (b) Subsection (a)(2) applies to an entity chartered by the
23 federal Farm Credit Administration, as provided by the farm credit
24 system under 12 U.S.C. Section 2001 et seq., as amended.

25 (c) This section does not apply to a person who wrote for the
26 previous calendar year:

27 (1) policies authorized by Chapter 911 for a farm

1 mutual insurance company that generated, in the aggregate, less
2 than \$50,000 in direct premium; or

3 (2) industrial fire insurance policies that
4 generated, in the aggregate, less than \$20,000 in direct premium.
5 (V.T.I.C. Art. 21.14, Secs. 6(a), (b), (d).)

6 Sec. 4051.102. DESIGNATION OF KINDS OF INSURANCE. A person
7 who holds a limited property and casualty license may write only the
8 kind of insurance designated on the license. (V.T.I.C. Art. 21.14,
9 Sec. 6(c).)

10 [Sections 4051.103-4051.150 reserved for expansion]

11 SUBCHAPTER D. INSURANCE SERVICE REPRESENTATIVE LICENSE

12 Sec. 4051.151. LICENSE REQUIRED. A person is required to
13 hold an insurance service representative license if the person is a
14 salaried employee who performs assigned duties only in an office of
15 a property and casualty agent, including explaining insurance
16 coverage, describing an insurance product, quoting insurance
17 premium rates, and issuing insurance binders only with the express
18 approval of the property and casualty agent who supervises the
19 license holder. (V.T.I.C. Art. 21.14, Sec. 8(a).)

20 Sec. 4051.152. APPLICABILITY OF CERTAIN REQUIREMENTS. The
21 provisions of this title that apply to the holder of a general
22 property and casualty license apply to the holder of a license
23 issued under this subchapter, except that proof of financial
24 responsibility is not required for a person licensed only under
25 this subchapter. (V.T.I.C. Art. 21.14, Sec. 8(b).)

26 [Sections 4051.153-4051.200 reserved for expansion]

27 SUBCHAPTER E. COUNTY MUTUAL AGENT LICENSE

1 Sec. 4051.201. LICENSE ISSUANCE. The department shall
2 issue a license to an individual applicant to act as an agent for a
3 county mutual insurance company under Chapter 912 on receipt of
4 certification from the company that the applicant has:

5 (1) completed a course of study and instruction in
6 compliance with this subchapter; and

7 (2) passed without aid a written examination
8 administered by the company. (V.T.I.C. Art. 21.14, Sec. 9(a)
9 (part).)

10 Sec. 4051.202. COURSE. (a) To be eligible to receive a
11 license under this subchapter, an applicant must complete a course
12 of study and instruction offered by the applicable company on motor
13 vehicle insurance and insurance covering dwellings.

14 (b) The course of study and instruction must:

15 (1) be at least five hours in duration; and

16 (2) include instruction on:

17 (A) the policies to be sold; and

18 (B) the laws relating to the regulation of
19 insurance in this state. (V.T.I.C. Art. 21.14, Secs. 9(a) (part),
20 (b).)

21 Sec. 4051.203. EXAMINATION. (a) The commissioner shall
22 prescribe a uniform examination for applicants that fairly tests
23 knowledge of the information contained in the course provided under
24 Section 4051.202.

25 (b) The department shall authorize a county mutual
26 insurance company to administer the examination after approval by
27 the department of a complete outline and explanation of the course

1 and the manner of conducting the examination. (V.T.I.C. Art.
2 21.14, Sec. 9(c).)

3 Sec. 4051.204. INVESTIGATION BY DEPARTMENT. The department
4 may investigate as necessary the manner of instruction and the
5 examination administered by a company under this subchapter.
6 (V.T.I.C. Art. 21.14, Sec. 9(d) (part).)

7 Sec. 4051.205. WITHDRAWAL OF COMPANY'S AUTHORITY. The
8 department may withdraw from a county mutual insurance company the
9 authority under this subchapter to offer instruction and administer
10 an examination. (V.T.I.C. Art. 21.14, Sec. 9(d) (part).)

11 Sec. 4051.206. APPLICABILITY OF LIMITED LICENSE LAWS.
12 Except as specifically provided by this subchapter, the provisions
13 of this title that apply to the holder of a limited license apply to
14 the holder of a license issued under this subchapter. (V.T.I.C.
15 Art. 21.14, Sec. 9(e).)

16 [Sections 4051.207-4051.250 reserved for expansion]

17 SUBCHAPTER F. AGRICULTURAL INSURANCE AGENT

18 Sec. 4051.251. APPOINTMENT OF AGENT. (a) An insurer that
19 holds a valid certificate of authority to engage in the business of
20 insurance in this state and whose authority in this state and each
21 other jurisdiction in which the insurer is authorized to engage in
22 the business of insurance is limited to the business of insuring
23 risks on growing crops may, subject to this subchapter, appoint and
24 act through an agent licensed under Subchapter B, C, or E.

25 (b) An agent appointed under Subsection (a) may act as an
26 agent for more than one insurer but may act as an agent under this
27 subchapter only with respect to the business of insuring risks on

1 growing crops.

2 (c) This title applies to the licensing and regulation of an
3 agent appointed under this subchapter. (V.T.I.C. Art. 21.14-2,
4 Secs. 1, 3, 4.)

5 Sec. 4051.252. REQUIREMENTS FOR APPOINTMENT; PROCEDURE.

6 (a) To appoint an agent under this subchapter, an insurer must
7 submit a completed appointment form to the department and pay a
8 nonrefundable fee in an amount set by the department.

9 (b) The appointment form must be signed by a representative
10 of the insurer.

11 (c) The department shall approve an appointment unless the
12 department determines that the applicant does not meet the
13 requirements of this title.

14 (d) The department may waive any examination requirement
15 imposed by this title for a license applicant seeking an
16 appointment under this subchapter who has passed an examination as
17 required by Federal Crop Insurance Corporation guidelines for
18 administering the federal crop insurance program. (V.T.I.C. Art.
19 21.14-2, Secs. 2(a), (b), (c).)

20 Sec. 4051.253. ACCEPTANCE OF CERTAIN CONTINUING EDUCATION.

21 The department may accept continuing education hours completed
22 under the guidelines of the Federal Crop Insurance Corporation as
23 satisfying the continuing education requirements imposed under
24 this title. (V.T.I.C. Art. 21.14-2, Sec. 2(d).)

25 Sec. 4051.254. RULES. The commissioner may adopt rules
26 necessary to implement this subchapter and to meet the minimum
27 requirements of federal law, including regulations. (V.T.I.C. Art.

21.14-2, Sec. 5.)

[Sections 4051.255-4051.300 reserved for expansion]

SUBCHAPTER G. REGISTRATION OF HOME OFFICE EMPLOYEES

Sec. 4051.301. REGISTRATION AND DISCLOSURE REQUIRED; FEE.

(a) A person is required to be registered with the department if the person acts as a full-time home office salaried employee who solicits or receives an application for the sale of insurance through an oral, written, or electronic communication for an insurer authorized to engage in the business of insurance in this state.

(b) A person who registers under this section must submit a nonrefundable registration fee in an amount set by the department.

(c) A person registered under this section shall disclose that the person is registered on making an oral, written, or electronic communication to solicit or receive an application for the sale of insurance. (V.T.I.C. Art. 21.14, Secs. 7(a), (d), (e).)

Sec. 4051.302. CONTINUING EDUCATION REQUIREMENTS. (a) An insurer authorized to engage in the business of insurance in this state whose general plan of operation includes the use of employees described by Section 4051.301 shall certify to the department that each of those employees receives at least 15 hours of continuing education annually.

(b) Each continuing education course provided by the insurer must be submitted to the department for certification as provided by Chapter 4004.

(c) A person registered under this subchapter shall comply with the continuing education requirements imposed by Chapter 4004

1 as if the person were a licensed agent.

2 (d) The continuing education required by this section must
3 be designed to give the employees:

4 (1) reasonable familiarity with:

5 (A) the broad principles of insurance;

6 (B) insurance licensing and regulatory laws; and

7 (C) the terms and conditions of the insurance
8 that the employees transact;

9 (2) a fair and general understanding of the duties of
10 an insurer to an insured; and

11 (3) training in ethical considerations. (V.T.I.C.
12 Art. 21.14, Sec. 7(b).)

13 Sec. 4051.303. SUSPENSION OF REGISTERED EMPLOYEE;
14 DISCIPLINARY ACTION AGAINST INSURER. The registration of an
15 employee under this subchapter shall be suspended and the insurer
16 who employs the registered employee may be disciplined for any act
17 for which an agent may be disciplined under Subchapter C, Chapter
18 4005. (V.T.I.C. Art. 21.14, Sec. 7(c).)

19 [Sections 4051.304-4051.350 reserved for expansion]

20 SUBCHAPTER H. TERMINATION OR SUSPENSION OF AGENT CONTRACTS
21 BY PROPERTY AND CASUALTY INSURERS

22 Sec. 4051.351. APPLICABILITY OF SUBCHAPTER. (a) Except as
23 provided by Subsection (b), this subchapter applies to each
24 contract between an agent and an insurer engaged in the business of
25 property and casualty insurance in this state.

26 (b) This subchapter does not apply to:

27 (1) the termination or suspension by an insurer of an

1 agent's contract because of:

2 (A) insolvency;

3 (B) abandonment;

4 (C) gross and wilful misconduct;

5 (D) failure to pay the insurer money due to the
6 insurer after receipt of a written demand; or

7 (E) revocation of the agent's license by the
8 department; or

9 (2) the termination or suspension by an insurer of an
10 agent's contract if the insurance policies and insurance business
11 are owned by the insurer rather than the agent. (V.T.I.C. Art.
12 21.11-1, Secs. 3, 4.)

13 Sec. 4051.352. SUSPENSION OF AGENT'S CONTRACT; OTHER
14 DEFINITIONS. (a) For purposes of this subchapter, "suspension,"
15 with regard to an agent's contract, means the temporary cessation
16 of business relations between an insurer and an agent and refusal by
17 the insurer to accept insurance contracts submitted by the agent.
18 The term does not include a situation in which business is suspended
19 immediately after a natural disaster.

20 (b) The commissioner shall adopt reasonable rules to
21 provide definitions necessary to accomplish the purposes of this
22 subchapter. (V.T.I.C. Art. 21.11-1, Secs. 1(a) (part), (f).)

23 Sec. 4051.353. NOTICE REQUIRED BEFORE TERMINATION OR
24 SUSPENSION OF CONTRACT. (a) An insurer may not terminate or
25 suspend a contract with an appointed agent that has been in effect
26 for at least two years unless the insurer provides written notice of
27 the termination or suspension to the agent at least six months

1 before the date the termination or suspension takes effect.

2 (b) A contract that replaces or revises a contract that has
3 been in effect for at least two years is subject to this subchapter
4 if there has not been a material change in the ownership of the
5 agency. (V.T.I.C. Art. 21.11-1, Secs. 1(a) (part), (e).)

6 Sec. 4051.354. AUTOMATIC TERMINATION OF CONTRACT ON
7 WITHDRAWAL FROM STATE OR REDUCTION OF BUSINESS. (a) An insurer
8 that withdraws from this state or reduces the insurer's total
9 annual premium volume by at least 75 percent in any year is
10 considered to have terminated the contracts of the insurer's
11 agents. Except as provided by Subsection (b), the insurer shall
12 comply with the requirements of this subchapter.

13 (b) An insurer described by Subsection (a) shall renew each
14 contract for property and casualty insurance for the affected agent
15 for 24 months from the date of the notice of termination or
16 suspension of the contract.

17 (c) This section does not apply to the transfer of business
18 from an insurer to another insurer with which the agent has a
19 contract and that:

- 20 (1) is under common ownership; and
21 (2) is admitted to engage in the business of insurance
22 in this state. (V.T.I.C. Art. 21.11-1, Sec. 5.)

23 Sec. 4051.355. RENEWAL OF INSURANCE CONTRACTS AFTER NOTICE
24 OF TERMINATION OR SUSPENSION. (a) Except as provided by Subsection
25 (b), an insurer that terminates or suspends an agent's contract
26 with an appointed agent shall renew all contracts for property and
27 casualty insurance for the agent during the six months after the

1 effective date of the termination or suspension of the contract.

2 (b) The insurer may decline to renew an insurance contract
3 if any risk does not meet the insurer's current underwriting
4 standards. The insurer must provide at least 60 days' notice to the
5 agent of the insurer's intent not to renew the contract.

6 (c) An insurer that renews an insurance contract under this
7 section shall pay to the agent commissions for the renewal
8 according to the commission schedule that was in effect for the
9 agent before the insurer's decision to terminate or suspend the
10 agent's contract.

11 (d) An insurer that renews an insurance contract under this
12 section may not require the agent to convert from agency billing to
13 company billing during the termination period unless the agent
14 agrees in writing to the conversion. (V.T.I.C. Art. 21.11-1, Sec.
15 1(b) (part).)

16 Sec. 4051.356. INSURER REFUSAL TO RENEW AGENT'S BUSINESS
17 PROHIBITED. During the term of the agent's contract, the insurer
18 may not refuse to renew business from the agent that complies with
19 the underwriting standards in effect for agents of the insurer
20 whose contracts have not been terminated or suspended. (V.T.I.C.
21 Art. 21.11-1, Sec. 2.)

22 Sec. 4051.357. INSURER APPROVAL FOR NEW BUSINESS OR
23 INCREASE IN LIABILITY. An agent who receives notice of termination
24 or suspension of the agent's contract from an insurer may not write,
25 without the written approval of the insurer:

26 (1) any new business; or

27 (2) any increase in liability on a renewal policy or an

1 existing policy. (V.T.I.C. Art. 21.11-1, Sec. 1(c).)

2 Sec. 4051.358. PROVISION OF UNDERWRITING STANDARDS TO AGENT
3 WHOSE CONTRACT IS TERMINATED OR SUSPENDED. (a) On providing notice
4 to an agent of termination or suspension of the agent's contract
5 under this subchapter, the insurer shall provide to the agent the
6 insurer's written underwriting standards. The standards must
7 conform to the underwriting standards that were in effect for that
8 agent before the insurer's decision to terminate or suspend the
9 agent's contract.

10 (b) An insurer may provide different underwriting standards
11 to different agents of the insurer if the standards are not used in
12 a way that prevents or discourages the renewal of the insurance
13 policies of an agent whose contract is terminated or suspended.
14 (V.T.I.C. Art. 21.11-1, Sec. 1(b) (part).)

15 Sec. 4051.359. PAYMENT OF MONEY DUE INSURER. An insurer
16 shall allow an agent whose contract has been terminated or
17 suspended under this subchapter to pay to the insurer all money due
18 under the same accounts current payment terms in effect for agents
19 of the insurer whose contracts have not been terminated or
20 suspended. (V.T.I.C. Art. 21.11-1, Sec. 1(b) (part).)

21 Sec. 4051.360. REVISION OF TERMINATION PROVISIONS OF
22 AGENT'S CONTRACT. (a) This subchapter does not prohibit an
23 amendment of or addendum to an agent's contract providing that the
24 contract may be terminated before the time required by this
25 subchapter if the agent agrees in writing to the earlier
26 termination.

27 (b) An insurer that proposes to revise the termination

1 provisions of an agent's contract must first present the agent with
2 a separate written impact statement that summarizes any effect that
3 the proposed amendment or addendum would have on the agent's rights
4 under this subchapter. (V.T.I.C. Art. 21.11-1, Sec. 1(d).)

5 Sec. 4051.361. ADMINISTRATIVE PENALTY. If the department
6 determines that an insurer has violated this subchapter, the
7 insurer is subject to an administrative penalty as provided by
8 Chapter 84 of not less than \$1,000 or more than \$10,000. (V.T.I.C.
9 Art. 21.11-1, Sec. 6.)

10 Sec. 4051.362. ACTION FOR DAMAGES. An agent who has
11 sustained actual damages as a result of an insurer's violation of
12 this subchapter may bring an action against the insurer regardless
13 of whether the department has determined that there has been a
14 violation of this subchapter. (V.T.I.C. Art. 21.11-1, Sec. 7.)

15 CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS

16 SUBCHAPTER A. GENERAL PROVISIONS

17 Sec. 4052.001. DEFINITION

18 Sec. 4052.002. USE OF CERTAIN TITLES NOT PROHIBITED

19 Sec. 4052.003. APPLICABILITY OF OTHER LAW

20 Sec. 4052.004. EXEMPTIONS

21 Sec. 4052.005. RULES

22 [Sections 4052.006-4052.050 reserved for expansion]

23 SUBCHAPTER B. LICENSE REQUIREMENTS

24 Sec. 4052.051. LICENSE REQUIRED

25 Sec. 4052.052. EXAMINATION

26 Sec. 4052.053. APPOINTMENT TO ACT FOR INSURER NOT REQUIRED

27 Sec. 4052.054. LIMITS ON ADVERTISING

1 Sec. 4052.055. DUAL COMPENSATION PROHIBITED

2 Sec. 4052.056. ELIGIBILITY FOR NEW LICENSE AFTER
3 REVOCATION

4 [Sections 4052.057-4052.100 reserved for expansion]

5 SUBCHAPTER C. ENFORCEMENT OF COUNSELOR'S AGREEMENT

6 Sec. 4052.101. ENFORCEMENT OF AGREEMENT

7 CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS

8 SUBCHAPTER A. GENERAL PROVISIONS

9 Sec. 4052.001. DEFINITION. In this chapter, "life and
10 health insurance counselor" means a person who:

11 (1) for compensation, offers to examine or examines a
12 life, accident, or health insurance policy, a health benefit plan,
13 or an annuity or pure endowment contract to give advice or other
14 information regarding:

15 (A) the policy, plan, or contract terms,
16 conditions, benefits, coverage, or premiums; or

17 (B) the advisability of:

18 (i) changing, exchanging, converting,
19 replacing, surrendering, continuing, or rejecting a policy, plan,
20 or contract; or

21 (ii) accepting or procuring a policy, plan,
22 or contract from an insurer or health benefit plan issuer; or

23 (2) in any public manner:

24 (A) uses as a title:

25 (i) "insurance adviser";

26 (ii) "insurance analyst";

27 (iii) "insurance counselor";

- (iv) "insurance specialist";
- (v) "policyholders' adviser";
- (vi) "policyholders' counselor"; or
- (vii) any other similar title; or

(B) uses any other title indicating that the person gives or is engaged in the business of giving advice or other information to an insured, a beneficiary, or any other person having an interest in a life, accident, or health insurance policy, a health benefit plan, or an annuity or pure endowment contract. (V.T.I.C. Art. 21.07-2, Sec. 1 (part).)

Sec. 4052.002. USE OF CERTAIN TITLES NOT PROHIBITED. This chapter does not prohibit a person who, through the completion of a course of instruction recognized in the business of insurance, is designated as a chartered life underwriter (CLU), chartered financial consultant (ChFC), or certified financial planner (CFP) from using that designation to indicate professional achievement. (V.T.I.C. Art. 21.07-2, Sec. 1 (part).)

Sec. 4052.003. APPLICABILITY OF OTHER LAW. Except as provided by this chapter, the provisions of this title that apply to the licensing and regulation of agents apply to the licensing and regulation of a life and health insurance counselor. (V.T.I.C. Art. 21.07-2, Secs. 5(a) (part), 6.)

Sec. 4052.004. EXEMPTIONS. This chapter does not apply to:

- (1) a licensed agent for a life insurance company while acting as an agent for the company;
- (2) a licensed attorney at law of this state while acting in the course or scope of the attorney's profession;

1 (3) a licensed public accountant of this state while
2 acting in the course or scope of the accountant's profession;

3 (4) a regular salaried officer or employee of an
4 authorized insurer issuing policies of life or health insurance
5 while acting for the insurer in discharging the duties of the
6 position or employment;

7 (5) an officer or employee of a bank or trust company
8 who does not receive compensation from a source other than the bank
9 or trust company for activities connected with the position or
10 employment; or

11 (6) an employer, an employer's officer or employee, or
12 a trustee of an employee benefit plan to the extent that the
13 employer, officer, employee, or trustee is engaged in the
14 administration or operation of an employee benefit program that
15 involves the use of insurance or annuities issued by a legal reserve
16 life insurer. (V.T.I.C. Art. 21.07-2, Sec. 3.)

17 Sec. 4052.005. RULES. The commissioner may adopt rules
18 necessary to implement this chapter and to meet the minimum
19 requirements of federal law, including regulations. (V.T.I.C. Art.
20 21.07-2, Sec. 10.)

21 [Sections 4052.006-4052.050 reserved for expansion]

22 SUBCHAPTER B. LICENSE REQUIREMENTS

23 Sec. 4052.051. LICENSE REQUIRED. A person may not act as a
24 life and health insurance counselor unless the person holds a
25 license issued by the department under this chapter. (V.T.I.C.
26 Art. 21.07-2, Sec. 2.)

27 Sec. 4052.052. EXAMINATION. (a) An applicant for a life

1 and health insurance counselor license must take an examination
2 administered under Chapter 4002 that includes the following:

- 3 (1) fundamentals of life and health insurance;
- 4 (2) group life insurance, pensions, and health
5 insurance;
- 6 (3) law, trust, and taxation;
- 7 (4) finance and economics; and
- 8 (5) business insurance and estate planning.

9 (b) The department may not issue a life and health insurance
10 counselor license to a person unless the person has passed each part
11 of the examination.

12 (c) The department may schedule and give the examination.
13 (V.T.I.C. Art. 21.07-2, Secs. 5(b), (c) (part).)

14 Sec. 4052.053. APPOINTMENT TO ACT FOR INSURER NOT REQUIRED.
15 An appointment to act for an insurer is not a condition to the
16 issuance of a life and health insurance counselor license.
17 (V.T.I.C. Art. 21.07-2, Sec. 5(a) (part).)

18 Sec. 4052.054. LIMITS ON ADVERTISING. A life and health
19 insurance counselor may not advertise in any manner and may not
20 circulate materials indicating professional superiority or the
21 performance of professional service in a superior manner.
22 (V.T.I.C. Art. 21.07-2, Sec. 5(a) (part).)

23 Sec. 4052.055. DUAL COMPENSATION PROHIBITED. A life and
24 health insurance counselor is not entitled to receive compensation
25 for the same service provided to the same client if the counselor:

- 26 (1) holds a license under Chapter 4054; and
- 27 (2) receives compensation for the service as an agent

1 licensed under that chapter. (V.T.I.C. Art. 21.07-2, Sec. 4a.)

2 Sec. 4052.056. ELIGIBILITY FOR NEW LICENSE AFTER
3 REVOCATION. If the department revokes a life and health insurance
4 counselor's license, the license holder is not eligible for a new
5 license until the second anniversary of the revocation date.
6 (V.T.I.C. Art. 21.07-2, Sec. 7 (part).)

7 [Sections 4052.057-4052.100 reserved for expansion]

8 SUBCHAPTER C. ENFORCEMENT OF COUNSELOR'S AGREEMENT

9 Sec. 4052.101. ENFORCEMENT OF AGREEMENT. A life and health
10 insurance counselor, or a person acting on the counselor's behalf,
11 may enforce an agreement between the counselor and a person, firm,
12 or corporation relating to the services of the counselor only if:

13 (1) the agreement is in writing;

14 (2) the agreement is executed in duplicate by the
15 person, firm, or corporation to be charged;

16 (3) a duplicate is delivered to and retained by the
17 person, firm, or corporation when executed; and

18 (4) the agreement specifies:

19 (A) the amount of the compensation paid or to be
20 paid to the counselor; and

21 (B) the services to be provided by the counselor.

22 (V.T.I.C. Art. 21.07-2, Sec. 4 (part).)

23 CHAPTER 4053. MANAGING GENERAL AGENTS

24 SUBCHAPTER A. GENERAL PROVISIONS

25 Sec. 4053.001. DEFINITIONS

26 Sec. 4053.002. EXCEPTION

27 Sec. 4053.003. INAPPLICABILITY OF CHAPTER

1 Sec. 4053.004. REGULATION OF MANAGING GENERAL AGENTS

2 Sec. 4053.005. RULES

3 [Sections 4053.006-4053.050 reserved for expansion]

4 SUBCHAPTER B. LICENSE REQUIREMENTS

5 Sec. 4053.051. LICENSE REQUIRED; EXEMPTIONS

6 Sec. 4053.052. ISSUANCE OF TEMPORARY OR EMERGENCY

7 LICENSE

8 Sec. 4053.053. SINGLE LICENSE REQUIRED

9 Sec. 4053.054. NOTICE AND APPROVAL OF APPOINTMENT

10 Sec. 4053.055. LAPSE OF LICENSE

11 [Sections 4053.056-4053.100 reserved for expansion]

12 SUBCHAPTER C. POWERS AND DUTIES OF MANAGING

13 GENERAL AGENTS

14 Sec. 4053.101. GENERAL POWERS AND DUTIES

15 Sec. 4053.102. CONTRACTS

16 Sec. 4053.103. ACCOUNT REPORT

17 Sec. 4053.104. SEPARATE RECORDS

18 Sec. 4053.105. ESCROW ACCOUNT

19 Sec. 4053.106. FIDUCIARY CAPACITY

20 Sec. 4053.107. FINANCIAL EXAMINATION

21 Sec. 4053.108. REQUIRED NOTICES TO DEPARTMENT

22 Sec. 4053.109. REINSURANCE

23 Sec. 4053.110. REDEMPTION OF CORPORATE SHARES

24 [Sections 4053.111-4053.150 reserved for expansion]

25 SUBCHAPTER D. ENFORCEMENT

26 Sec. 4053.151. DISCIPLINARY ACTION

27 Sec. 4053.152. GUARANTY FUND REIMBURSEMENT

CHAPTER 4053. MANAGING GENERAL AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4053.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who is classified as an affiliate under Section 823.003(a).

(2) "Insurer" means an insurance company, carrier, corporation, reciprocal or interinsurance exchange, mutual, association, county mutual insurance company, Lloyd's plan, or other insurance carrier authorized to engage in the business of insurance in this state.

(3) "Managing general agent" means a person, firm, or corporation that has supervisory responsibility for the local agency and field operations of an insurer in this state or that is authorized by an insurer to accept or process on the insurer's behalf insurance policies produced and sold by other agents. (V.T.I.C. Art. 21.07-3, Secs. 2(a) (part), (b) (part), (e).)

Sec. 4053.002. EXCEPTION. An agent licensed under Subchapter E of Chapter 981, Subchapters B-E of Chapter 4051, or Chapter 4056 is not a managing general agent unless the agent accepts 50 percent or more of the agent's total annual business or does \$500,000 or more of total annual business as measured by premium volume, whichever amount is less, from insurance policies produced and sold by other agents. (V.T.I.C. Art. 21.07-3, Sec. 2(a) (part).)

Sec. 4053.003. INAPPLICABILITY OF CHAPTER. This chapter does not apply to:

(1) the transaction of the business of life, health,

1 and accident insurance, including variable life insurance and
2 variable annuity contracts;

3 (2) a full-time salaried employee of an insurer acting
4 for and in connection with the insurance business of the insurer; or

5 (3) an adjuster or inspector of risks for an insurer.
6 (V.T.I.C. Art. 21.07-3, Secs. 2(b) (part), 16.)

7 Sec. 4053.004. REGULATION OF MANAGING GENERAL AGENTS. This
8 title applies to the licensing and regulation of a person acting as
9 a managing general agent. (V.T.I.C. Art. 21.07-3, Sec. 19(a).)

10 Sec. 4053.005. RULES. The commissioner may adopt
11 reasonable rules for the administration of this chapter. (V.T.I.C.
12 Art. 21.07-3, Sec. 21.)

13 [Sections 4053.006-4053.050 reserved for expansion]

14 SUBCHAPTER B. LICENSE REQUIREMENTS

15 Sec. 4053.051. LICENSE REQUIRED; EXEMPTIONS. (a) Except
16 as provided by Subsection (b), a person, firm, or corporation may
17 not act as a managing general agent unless the person, firm, or
18 corporation holds a license issued under this chapter.

19 (b) A business corporation is not required to hold a license
20 issued under this chapter to act as a managing general agent if:

21 (1) the corporation is authorized to engage in
22 business in this state;

23 (2) all of the corporation's outstanding stock is
24 solely owned by an insurer authorized to engage in business in this
25 state and the corporation's business affairs are completely
26 controlled by that insurer;

27 (3) the principal purpose for which the corporation

1 exists is to facilitate the accumulation of commissions from the
2 insurer and its subsidiaries and affiliates for the account of and
3 payment to an agent who could otherwise lawfully receive the
4 commissions directly from the insurer and its subsidiaries and
5 affiliates; and

6 (4) the corporation does not engage in any other act of
7 a managing general agent as provided by this chapter.

8 (c) Notwithstanding Subsection (b), the managing general
9 agent shall execute on the insurer's behalf a contract entered into
10 with an agent. (V.T.I.C. Art. 21.07-3, Sec. 3.)

11 Sec. 4053.052. ISSUANCE OF TEMPORARY OR EMERGENCY LICENSE.
12 The commissioner may, without requiring an examination, issue a
13 temporary or emergency license under this chapter to an applicant
14 for a period not to exceed six months:

15 (1) on the death or disability of a managing general
16 agent or for another good cause satisfactory to the commissioner;
17 and

18 (2) if the applicant meets the other requirements of
19 this chapter. (V.T.I.C. Art. 21.07-3, Sec. 7.)

20 Sec. 4053.053. SINGLE LICENSE REQUIRED. A license issued
21 under this chapter entitles the license holder to represent or act
22 for one or more insurers as a managing general agent. The license
23 holder is not required to hold a separate license for each insurer
24 the license holder represents. (V.T.I.C. Art. 21.07-3, Sec.
25 11(a).)

26 Sec. 4053.054. NOTICE AND APPROVAL OF APPOINTMENT. (a)
27 Each appointment to act as a managing general agent shall be

1 reported to the commissioner on a form prescribed by the
2 commissioner.

3 (b) The form must include:

4 (1) the details required by rules adopted under this
5 chapter;

6 (2) the insurer's name and identifying number;

7 (3) the managing general agent's name and address;

8 (4) a statement by an officer of the insurer that the
9 officer or the officer's agent has personal knowledge that the
10 managing general agent has had experience or instruction that
11 qualifies the agent to act as a managing general agent;

12 (5) a statement of whether the managing general agent
13 may exercise claim settlement authority for the insurer and, if so:

14 (A) whether that authority exceeds \$25,000 on any
15 one claim; and

16 (B) whether that authority includes third-party
17 liability other than property damage; and

18 (6) a statement of whether funds exceeding \$100,000
19 are customarily held by the managing general agent to pay losses and
20 loss adjustment expenses for the insurer.

21 (c) For each additional appointment for which a managing
22 general agent applies, the agent shall pay a nonrefundable fee in an
23 amount not to exceed \$16 as determined by the department.

24 (d) If approval of an additional appointment is not received
25 from the commissioner before the eighth day after the date the
26 commissioner receives the completed application and fee, the
27 managing general agent and insurer may assume, in the absence of

notice of disapproval from the commissioner, that the commissioner approves the application and the managing general agent may act for the insurer. (V.T.I.C. Art. 21.07-3, Secs. 11(c), (d), (e).)

Sec. 4053.055. LAPSE OF LICENSE. If a license holder is not appointed or under appointment to represent an insurer at the time the license is subject to renewal, the license lapses and the commissioner shall deny the renewal application. (V.T.I.C. Art. 21.07-3, Sec. 11(b).)

[Sections 4053.056-4053.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF MANAGING GENERAL AGENTS

Sec. 4053.101. GENERAL POWERS AND DUTIES. A managing general agent acting for an insurer may:

- (1) receive and pass on daily reports and monthly accounts;
- (2) receive and be responsible for agency balances;
- (3) handle the adjustment of losses; or
- (4) appoint or direct general property and casualty agents in this state. (V.T.I.C. Art. 21.07-3, Sec. 2(a) (part).)

Sec. 4053.102. CONTRACTS. (a) An insurer may not accept business from a managing general agent and the agent may not place business with the insurer without a written contract that addresses:

- (1) the responsibilities of each party;
- (2) cancellation or termination;
- (3) reports, records, and auditing; and
- (4) if applicable:
 - (A) premium volume limits;

- (B) appointment or cancellation of agents;
- (C) claims settlement;
- (D) underwriting; and
- (E) reinsurance.

(b) The commissioner may adopt rules establishing requirements for a contract with a managing general agent.

(c) A contract with a managing general agent and a report or record submitted under that contract are subject to review by the department under Section 38.001. (V.T.I.C. Art. 21.07-3, Sec. 3A.)

Sec. 4053.103. ACCOUNT REPORT. (a) At least once each calendar quarter, a managing general agent shall submit an account report to each insurer with whom the agent has a contract.

(b) The account report must include, as applicable, a statement of:

- (1) written, earned, and unearned premiums;
- (2) losses and loss expenses paid and outstanding;
- (3) losses incurred but not reported; and
- (4) management fees. (V.T.I.C. Art. 21.07-3, Sec.

3C(a).)

Sec. 4053.104. SEPARATE RECORDS. (a) For each insurer with which a managing general agent has a contract, the agent shall maintain separate records of the business handled by the agent for the insurer.

(b) The managing general agent shall make a record required under Subsection (a) available for inspection by:

- (1) each insurer; and
- (2) the department's examiners. (V.T.I.C. Art.

1 21.07-3, Sec. 3C(b).)

2 Sec. 4053.105. ESCROW ACCOUNT. (a) A managing general
3 agent shall maintain an escrow account in a bank that:

4 (1) is a member of the Federal Reserve System; and

5 (2) has its accounts insured by the Federal Deposit
6 Insurance Corporation.

7 (b) On receipt, the managing general agent shall deposit in
8 the escrow account all money collected for each insurer with which
9 the agent has a contract.

10 (c) Except as provided by the contract required by Section
11 4053.102, a managing general agent may not use, take as an offset,
12 or convert money that is or should have been deposited in the escrow
13 account. (V.T.I.C. Art. 21.07-3, Secs. 3C(c), (d).)

14 Sec. 4053.106. FIDUCIARY CAPACITY. A managing general
15 agent holds money on behalf of an insured or insurer in a fiduciary
16 capacity and shall properly account for that money as required by
17 law, department rules, and a contract with an insurer. The
18 department's examiners may audit money held in a fiduciary
19 capacity. (V.T.I.C. Art. 21.07-3, Sec. 3C(e).)

20 Sec. 4053.107. FINANCIAL EXAMINATION. (a) As the
21 commissioner considers necessary, a managing general agent shall
22 submit to an examination of the agent's financial condition and the
23 agent's compliance with the laws of this state affecting the
24 conduct of the agent's business.

25 (b) The examination may be conducted by:

26 (1) the commissioner;

27 (2) one or more commissioned examiners; or

1 (3) a certified public accountant or other person or
2 firm qualified to perform those examinations.

3 (c) The managing general agent shall pay the examination
4 expenses in an amount the commissioner certifies as just and
5 reasonable. (V.T.I.C. Art. 21.07-3, Sec. 3C(f).)

6 Sec. 4053.108. REQUIRED NOTICES TO DEPARTMENT. (a) On
7 forms prescribed by the department, a managing general agent shall
8 notify the department not later than the 30th day after the date any
9 of the following occurs:

10 (1) balances due to an insurer for more than 90 days
11 exceed:

12 (A) \$1 million; or

13 (B) 10 percent of the insurer's policyholder
14 surplus, as reported in the annual statement filed with the
15 department;

16 (2) balances due for more than 60 days from a property
17 and casualty agent or managing general agent appointed by or
18 reporting to the managing general agent exceed \$500,000;

19 (3) authority to settle claims for an insurer is
20 withdrawn;

21 (4) money held for an insurer for losses is greater
22 than an amount that is \$100,000 more than the amount necessary to
23 pay the losses and loss adjustment expenses expected to be paid on
24 the insurer's behalf within the next 60-day period; or

25 (5) the contract required under Section 4053.102 is
26 canceled or terminated.

27 (b) Notwithstanding the time limitation imposed by

1 Subsection (a), the requirement to file under Subsections (a)(1),
2 (2), and (4) may be met with a single annual report if:

3 (1) the managing general agent routinely operates
4 above the limits established by those subsections; and

5 (2) the department verifies that fact in accordance
6 with rules adopted by the commissioner. (V.T.I.C. Art. 21.07-3,
7 Sec. 11A.)

8 Sec. 4053.109. REINSURANCE. (a) A managing general agent
9 may not knowingly cede, arrange, facilitate, or bind an insurer to
10 reinsurance.

11 (b) Notwithstanding Subsection (a), a managing general
12 agent may bind a facultative reinsurance contract in accordance
13 with an obligatory facultative agreement if the contract with the
14 insurer contains reinsurance underwriting guidelines including,
15 for both assumed and ceded reinsurance:

16 (1) a list of reinsurers with whom the automatic
17 agreements are in effect;

18 (2) the coverages and amounts or percentages that may
19 be reinsured; and

20 (3) commission schedules.

21 (c) A managing general agent may not commit an insurer to
22 participate in insurance or reinsurance syndicates. (V.T.I.C. Art.
23 21.07-3, Sec. 3B.)

24 Sec. 4053.110. REDEMPTION OF CORPORATE SHARES. A
25 corporation acting as a managing general agent may redeem the
26 shares of a shareholder or a deceased shareholder:

27 (1) on terms agreed on by the board of directors and

1 the shareholder or the shareholder's personal representative; or

2 (2) at a price and on terms provided in the articles of
3 incorporation, the bylaws, or an existing contract entered into
4 between the shareholders. (V.T.I.C. Art. 21.07-3, Sec. 4.)

5 [Sections 4053.111-4053.150 reserved for expansion]

6 SUBCHAPTER D. ENFORCEMENT

7 Sec. 4053.151. DISCIPLINARY ACTION. A person, firm, or
8 corporation that violates this chapter or a rule or order adopted
9 under this title, including this chapter, is subject to:

10 (1) Subchapters B and C, Chapter 4005; and

11 (2) Chapter 82. (V.T.I.C. Art. 21.07-3, Sec. 19(b).)

12 Sec. 4053.152. GUARANTY FUND REIMBURSEMENT. (a) If a court
13 finds by a final nonappealable judgment that a violation of this
14 chapter by a managing general agent contributes materially to the
15 insolvency of an insurer under which the agent held an appointment,
16 the agent shall reimburse the appropriate guaranty fund for money
17 paid to cover losses of the insolvent insurer in an amount equal to
18 all payments made from that guaranty fund in excess of:

19 (1) gross earned premiums and investment income earned
20 on those premiums; and

21 (2) loss reserves for that business.

22 (b) The reimbursement made under this section shall be used
23 for losses, loss adjustments, and administrative expenses on
24 business placed by the managing general agent. (V.T.I.C. Art.
25 21.07-3, Sec. 19A.)

26 CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

27 SUBCHAPTER A. GENERAL PROVISIONS

1 Sec. 4054.001. APPLICABILITY OF CHAPTER

2 [Sections 4054.002-4054.050 reserved for expansion]

3 SUBCHAPTER B. GENERAL LIFE, ACCIDENT, AND

4 HEALTH LICENSE

5 Sec. 4054.051. LICENSE REQUIRED

6 Sec. 4054.052. COMBINATION LIFE INSURANCE AGENT

7 Sec. 4054.053. AUTHORITY TO WRITE ADDITIONAL LINES

8 [Sections 4054.054-4054.100 reserved for expansion]

9 SUBCHAPTER C. LIMITED LIFE, ACCIDENT, AND HEALTH LICENSE

10 Sec. 4054.101. LICENSE REQUIRED

11 Sec. 4054.102. DESIGNATION OF KINDS OF INSURANCE

12 Sec. 4054.103. TEMPORARY LICENSE

13 [Sections 4054.104-4054.150 reserved for expansion]

14 SUBCHAPTER D. FUNERAL PREARRANGEMENT LIFE

15 INSURANCE LICENSE

16 Sec. 4054.151. FUNERAL PREARRANGEMENT LIFE INSURANCE AGENT

17 Sec. 4054.152. LICENSE ISSUANCE

18 Sec. 4054.153. COURSE

19 Sec. 4054.154. EXAMINATION

20 Sec. 4054.155. INVESTIGATION BY DEPARTMENT

21 Sec. 4054.156. WITHDRAWAL OF INSURER'S AUTHORITY

22 Sec. 4054.157. LIMIT ON AGENT'S AUTHORITY

23 Sec. 4054.158. REVOCATION; NOTIFICATION

24 Sec. 4054.159. CONTINUING EDUCATION EXEMPTION

25 Sec. 4054.160. APPLICABILITY OF LIMITED LICENSE LAWS

26 [Sections 4054.161-4054.200 reserved for expansion]

27 SUBCHAPTER E. LIFE INSURANCE NOT EXCEEDING \$15,000

1 Sec. 4054.201. LICENSE ISSUANCE; EXCEPTION

2 Sec. 4054.202. COURSE

3 Sec. 4054.203. EXAMINATION

4 Sec. 4054.204. INVESTIGATION BY DEPARTMENT

5 Sec. 4054.205. WITHDRAWAL OF INSURER'S AUTHORITY

6 Sec. 4054.206. LIMIT ON AGENT'S AUTHORITY

7 Sec. 4054.207. CONTINUING EDUCATION EXEMPTION

8 Sec. 4054.208. APPLICABILITY OF LIMITED LICENSE LAWS

9 [Sections 4054.209-4054.250 reserved for expansion]

10 SUBCHAPTER F. RENEWAL OR SERVICE COMMISSIONS TO AGENTS

11 OF LIFE INSURANCE COMPANIES DISCONTINUING BUSINESS IN STATE

12 Sec. 4054.251. INSURANCE COMPANY LIABILITY FOR PAYMENT OF
13 COMMISSIONS

14 Sec. 4054.252. MONTHLY AND QUARTERLY STATEMENTS

15 Sec. 4054.253. PRESUMPTION IN LAWSUIT

16 CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

17 SUBCHAPTER A. GENERAL PROVISIONS

18 Sec. 4054.001. APPLICABILITY OF CHAPTER. (a) This chapter
19 applies to each agent of an insurer authorized to provide life,
20 accident, and health insurance coverage in this state.

21 (b) This chapter applies to each person who:

22 (1) performs the acts of an agent, as described by
23 Section 4001.051, whether through an oral, written, electronic, or
24 other form of communication by soliciting, negotiating, procuring,
25 or collecting a premium on an insurance or annuity contract offered
26 by any type of insurer authorized to engage in the business of life,
27 accident, and health insurance in this state; or

1 (2) represents or purports to represent a health
2 maintenance organization in soliciting, negotiating, procuring, or
3 effecting membership in the health maintenance organization.
4 (V.T.I.C. Art. 21.07-1, Sec. 1(b).)

5 [Sections 4054.002-4054.050 reserved for expansion]

6 SUBCHAPTER B. GENERAL LIFE, ACCIDENT, AND HEALTH LICENSE

7 Sec. 4054.051. LICENSE REQUIRED. A person is required to
8 hold a general life, accident, and health license if the person acts
9 as:

10 (1) an agent who represents a health maintenance
11 organization;

12 (2) an industrial life insurance agent for an insurer
13 that writes only weekly premium life insurance on a debit basis
14 under Chapter 1151;

15 (3) an agent who writes life, accident, and health
16 insurance for a life insurance company;

17 (4) an agent who writes only accident and health
18 insurance;

19 (5) an agent who writes fixed or variable annuity
20 contracts or variable life contracts;

21 (6) an agent who writes for a stipulated premium
22 company:

23 (A) only life insurance in excess of \$15,000 on
24 any one life;

25 (B) only accident and health insurance; or

26 (C) both kinds of insurance described by
27 Paragraphs (A) and (B);

1 (7) an agent who writes life, accident, and health
2 insurance for any type of authorized life insurance company that is
3 domiciled in this state, including a legal reserve life insurance
4 company, and who represents the company:

5 (A) in a foreign country or territory; and

6 (B) on a United States military installation or
7 with United States military personnel;

8 (8) an agent who writes life, accident, and health
9 insurance for a fraternal benefit society except as provided by
10 Section 885.352; or

11 (9) an agent who writes any other kind of insurance as
12 required by the commissioner for the protection of the insurance
13 consumers of this state. (V.T.I.C. Art. 21.07-1, Sec. 2(a).)

14 Sec. 4054.052. COMBINATION LIFE INSURANCE AGENT. (a) In
15 this section, a "combination company" means an insurer that writes
16 weekly premium life insurance or monthly ordinary life insurance on
17 a debit basis.

18 (b) A person may not act as a combination life insurance
19 agent for a combination company unless the person holds a general
20 life, accident, and health license.

21 (c) A combination company and a combination life insurance
22 agent may also write ordinary life insurance contracts. (V.T.I.C.
23 Art. 21.07-1, Sec. 2(b).)

24 Sec. 4054.053. AUTHORITY TO WRITE ADDITIONAL LINES. A
25 person who holds a general life, accident, and health license may,
26 without obtaining an additional license, write the kinds of
27 insurance contracts described by:

1 (1) Subchapter C, D, or E; or

2 (2) Chapter 4055. (V.T.I.C. Art. 21.07-1, Sec. 3.)

3 [Sections 4054.054-4054.100 reserved for expansion]

4 SUBCHAPTER C. LIMITED LIFE, ACCIDENT, AND HEALTH LICENSE

5 Sec. 4054.101. LICENSE REQUIRED. Except as provided by
6 Section 4054.053, an agent is required to hold a limited life,
7 accident, and health license if the agent writes:

8 (1) a policy or rider to a policy that provides only:

9 (A) lump-sum cash benefits in the event of
10 accidental death or dismemberment; or

11 (B) ambulance expense benefits in the event of
12 accident or sickness;

13 (2) a prepaid legal services contract under Article
14 5.13-1 or Chapter 961;

15 (3) credit insurance, except as otherwise provided by
16 Chapter 4055; or

17 (4) any other kind of insurance, if holding a limited
18 life, accident, and health license to write that kind of insurance
19 is determined necessary by the commissioner for the protection of
20 the insurance consumers of this state. (V.T.I.C. Art. 21.07-1,
21 Sec. 4(a).)

22 Sec. 4054.102. DESIGNATION OF KINDS OF INSURANCE. A person
23 who holds a limited life, accident, and health license may write
24 only the kind of insurance designated on the license. (V.T.I.C.
25 Art. 21.07-1, Sec. 4(b).)

26 Sec. 4054.103. TEMPORARY LICENSE. An applicant for a
27 limited life, accident, and health license is eligible for a

temporary license under Subchapter D, Chapter 4001. (V.T.I.C. Art. 21.07-1, Sec. 4(c).)

[Sections 4054.104-4054.150 reserved for expansion]

SUBCHAPTER D. FUNERAL PREARRANGEMENT LIFE INSURANCE LICENSE

Sec. 4054.151. FUNERAL PREARRANGEMENT LIFE INSURANCE AGENT. A funeral prearrangement life insurance agent is a life insurance agent who, subject to the limitations of this subchapter, writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code. (V.T.I.C. Art. 21.07-1, Sec. 5(a).)

Sec. 4054.152. LICENSE ISSUANCE. The department shall issue a license to an individual applicant to act as a funeral prearrangement life insurance agent on receipt of certification from an insurer authorized to write life insurance policies and fixed annuity contracts in this state that the applicant has:

(1) completed a course of study and instruction in compliance with this subchapter; and

(2) passed without aid a written examination administered by the insurer. (V.T.I.C. Art. 21.07-1, Sec. 5(b) (part).)

Sec. 4054.153. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by an insurer under this section on life insurance policies and fixed annuity contracts.

(b) The course of study and instruction must:

1 (1) be at least five hours in duration; and

2 (2) include instruction on:

3 (A) the life insurance policies and fixed annuity
4 contracts to be sold; and

5 (B) the laws relating to funeral prearrangement.
6 (V.T.I.C. Art. 21.07-1, Sec. 5(b) (part).)

7 Sec. 4054.154. EXAMINATION. (a) The commissioner shall
8 prescribe a uniform examination for applicants that fairly tests
9 knowledge of the information contained in the course under Section
10 4054.153.

11 (b) The department shall authorize an insurer to administer
12 the examination as provided by this section after approval by the
13 department of a complete outline and explanation of the course and
14 the manner of conducting the examination. (V.T.I.C. Art. 21.07-1,
15 Sec. 5(c).)

16 Sec. 4054.155. INVESTIGATION BY DEPARTMENT. The department
17 may investigate as necessary the manner of instruction and the
18 examination administered by an insurer under this subchapter.
19 (V.T.I.C. Art. 21.07-1, Sec. 5(d) (part).)

20 Sec. 4054.156. WITHDRAWAL OF INSURER'S AUTHORITY. The
21 department may withdraw from an insurer the authority under this
22 subchapter to offer instruction and administer an examination.
23 (V.T.I.C. Art. 21.07-1, Sec. 5(d) (part).)

24 Sec. 4054.157. LIMIT ON AGENT'S AUTHORITY. A funeral
25 prearrangement life insurance agent licensed under this subchapter
26 may not write any coverage or combination of coverages with an
27 initial guaranteed death benefit that exceeds \$15,000 on any life.

1 (V.T.I.C. Art. 21.07-1, Sec. 5(e) (part).)

2 Sec. 4054.158. REVOCATION; NOTIFICATION. (a) A license
3 issued under this subchapter to act as an agent for an insurer is
4 revoked if the license holder ceases to act as an agent for the
5 insurer.

6 (b) Not later than the 15th day after the date on which the
7 license holder ceases to act as an agent for an insurer, the insurer
8 or agent shall send written notification to the department.
9 (V.T.I.C. Art. 21.07-1, Sec. 5(f).)

10 Sec. 4054.159. CONTINUING EDUCATION EXEMPTION. (a)
11 Notwithstanding any other provision of this code, a funeral home
12 employee or other person who holds a funeral prearrangement life
13 insurance agent license and who writes only life insurance policies
14 and fixed annuity contracts to secure the delivery of funeral
15 services and merchandise under prepaid funeral contracts regulated
16 by the Texas Department of Banking under Chapter 154, Finance Code,
17 is not required to comply with any continuing education
18 requirements to maintain the license, except that the appointing
19 insurer must educate its appointed agents about any new products
20 sold by the agent to fund prepaid funeral contracts.

21 (b) A license holder to whom this section applies may be
22 appointed by more than one insurer. (V.T.I.C. Art. 21.07-1, Sec. 5B
23 (part).)

24 Sec. 4054.160. APPLICABILITY OF LIMITED LICENSE LAWS.
25 Except as specifically provided by this subchapter, the provisions
26 of this title that apply to the holder of a limited license apply to
27 the holder of a license issued under this subchapter. (V.T.I.C.

1 Art. 21.07-1, Sec. 5(g).)

2 [Sections 4054.161-4054.200 reserved for expansion]

3 SUBCHAPTER E. LIFE INSURANCE NOT EXCEEDING \$15,000

4 Sec. 4054.201. LICENSE ISSUANCE; EXCEPTION. (a) The
5 department shall issue a license to an individual applicant to act
6 as an agent who writes only life insurance policies in an amount
7 that does not exceed \$15,000 on any one life on receipt of
8 certification from a stipulated premium company, a statewide mutual
9 assessment company, a local mutual aid association, or a local
10 mutual burial association, that the applicant has:

11 (1) completed a course of study and instruction in
12 compliance with this subchapter; and

13 (2) passed without aid a written examination
14 administered by the insurer.

15 (b) A license is not required under this subchapter for an
16 agent who, in the preceding calendar year, wrote policies that
17 generated, in the aggregate, less than \$20,000 in direct premium.
18 (V.T.I.C. Art. 21.07-1, Secs. 6(a) (part), (e).)

19 Sec. 4054.202. COURSE. (a) To be eligible to receive a
20 license under this subchapter, an applicant must complete a course
21 of study and instruction offered by an insurer under this section on
22 life insurance and fixed annuities.

23 (b) The course of study and instruction must:

24 (1) be at least five hours in duration; and

25 (2) include instruction on:

26 (A) the policies to be sold; and

27 (B) the laws relating to the regulation of

1 insurance in this state. (V.T.I.C. Art. 21.07-1, Sec. 6(a)
2 (part).)

3 Sec. 4054.203. EXAMINATION. (a) The commissioner shall
4 prescribe a uniform examination for applicants that fairly tests
5 knowledge of the information contained in the course provided under
6 Section 4054.202.

7 (b) The department shall authorize an insurer described by
8 Section 4054.201 to administer the examination as provided by this
9 section after approval by the department of a complete outline and
10 explanation of the course and the manner of conducting the
11 examination. (V.T.I.C. Art. 21.07-1, Sec. 6(b).)

12 Sec. 4054.204. INVESTIGATION BY DEPARTMENT. The department
13 may investigate as necessary the manner of instruction and the
14 examination administered by an insurer under this subchapter.
15 (V.T.I.C. Art. 21.07-1, Sec. 6(c) (part).)

16 Sec. 4054.205. WITHDRAWAL OF INSURER'S AUTHORITY. The
17 department may withdraw from an insurer the authority under this
18 subchapter to offer instruction and administer an examination.
19 (V.T.I.C. Art. 21.07-1, Sec. 6(c) (part).)

20 Sec. 4054.206. LIMIT ON AGENT'S AUTHORITY. An insurance
21 agent licensed under this subchapter may not write any coverage or
22 combination of coverages with an initial guaranteed death benefit
23 that exceeds \$15,000 on any life. (V.T.I.C. Art. 21.07-1, Sec.
24 6(d).)

25 Sec. 4054.207. CONTINUING EDUCATION EXEMPTION. (a)
26 Notwithstanding any other provision of this code, a person who
27 holds a license under this subchapter and who writes only life

1 insurance policies and fixed annuity contracts to secure the
2 delivery of funeral services and merchandise under prepaid funeral
3 contracts regulated by the Texas Department of Banking under
4 Chapter 154, Finance Code, is not required to comply with any
5 continuing education requirements to maintain the license, except
6 that the appointing insurer must educate its appointed agents about
7 any new products sold by the agent to fund prepaid funeral
8 contracts.

9 (b) A license holder to whom this section applies may be
10 appointed by more than one insurer. (V.T.I.C. Art. 21.07-1, Sec. 5B
11 (part).)

12 Sec. 4054.208. APPLICABILITY OF LIMITED LICENSE LAWS.
13 Except as specifically provided by this subchapter, the provisions
14 of this title that apply to the holder of a limited license apply to
15 the holder of a license issued under this subchapter. (V.T.I.C.
16 Art. 21.07-1, Sec. 6(f).)

17 [Sections 4054.209-4054.250 reserved for expansion]

18 SUBCHAPTER F. RENEWAL OR SERVICE COMMISSIONS TO AGENTS
19 OF LIFE INSURANCE COMPANIES DISCONTINUING BUSINESS IN STATE

20 Sec. 4054.251. INSURANCE COMPANY LIABILITY FOR PAYMENT OF
21 COMMISSIONS. A life insurance company that discontinues the
22 business of issuing life insurance policies on the lives of
23 residents of this state remains liable for the payment of renewal or
24 service commissions on life insurance policies previously written
25 by the company under the terms of the company's contracts
26 previously made with agents residing in this state. (V.T.I.C. Art.
27 21.08 (part).)

1 Sec. 4054.252. MONTHLY AND QUARTERLY STATEMENTS. (a) A
2 life insurance company shall provide to each agent who may be
3 entitled to receive renewal or service commissions from the company
4 under Section 4054.251:

5 (1) a monthly statement that shows the policies
6 written by the agent for the company that terminated during the
7 month for which the statement is made; and

8 (2) at least quarterly, a detailed statement of all
9 policies written by the agent for the company on the lives of
10 residents of this state that shows:

11 (A) the policies in force; and

12 (B) the policies that have terminated, with the
13 reason for the termination.

14 (b) A life insurance company is not required to provide an
15 agent with a statement under this section after the expiration of
16 the period during which renewal or service commissions are payable
17 as to all of the policies written by the agent for the company.
18 (V.T.I.C. Art. 21.08 (part).)

19 Sec. 4054.253. PRESUMPTION IN LAWSUIT. In a suit against a
20 life insurance company for the recovery of a renewal or service
21 commission under this subchapter, a presumption exists that each
22 policy written by the company on the life of a resident of this
23 state by the agent bringing the suit continues in effect unless the
24 defendant proves the contrary by competent evidence. (V.T.I.C.
25 Art. 21.08 (part).)

26 CHAPTER 4055. SPECIALTY AGENTS

27 SUBCHAPTER A. GENERAL PROVISIONS

- 1 Sec. 4055.001. DEFINITION
- 2 Sec. 4055.002. APPLICABILITY OF CHAPTER TO CERTAIN
- 3 AGENTS
- 4 Sec. 4055.003. RULES
- 5 Sec. 4055.004. APPLICATION
- 6 Sec. 4055.005. LICENSE ISSUANCE
- 7 Sec. 4055.006. EXAMINATION AND CONTINUING EDUCATION NOT
- 8 REQUIRED
- 9 Sec. 4055.007. APPOINTMENT AS AGENT BY INSURER
- 10 Sec. 4055.008. GENERAL POWERS AND DUTIES
- 11 Sec. 4055.009. CERTAIN REPRESENTATIONS PROHIBITED
- 12 Sec. 4055.010. TREATMENT OF CERTAIN PREMIUMS
- 13 Sec. 4055.011. AUTHORITY OF EMPLOYEE OF SPECIALTY LICENSE
- 14 HOLDER
- 15 Sec. 4055.012. TRAINING REQUIRED TO ACT ON BEHALF OF SPECIALTY
- 16 LICENSE HOLDER
- 17 Sec. 4055.013. ASSIGNMENT AND TRANSFER OF COMPENSATION BY
- 18 CERTAIN AGENTS
- 19 Sec. 4055.014. DISCLOSURES REQUIRED BEFORE ISSUANCE OF
- 20 INSURANCE
- 21 Sec. 4055.015. VIOLATION BY SPECIALTY LICENSE HOLDER;
- 22 PENALTIES
- 23 [Sections 4055.016-4055.050 reserved for expansion]
- 24 SUBCHAPTER B. RENTAL CAR COMPANY LICENSE
- 25 Sec. 4055.051. DEFINITIONS
- 26 Sec. 4055.052. ISSUANCE OF LICENSE
- 27 Sec. 4055.053. AUTHORITY OF RENTAL CAR COMPANY OR

FRANCHISEE

[Sections 4055.054-4055.100 reserved for expansion]

SUBCHAPTER C. CREDIT INSURANCE LICENSE

Sec. 4055.101. GENERAL DEFINITIONS

Sec. 4055.102. DEFINITION OF CREDIT PROPERTY INSURANCE

Sec. 4055.103. ISSUANCE OF LICENSE

Sec. 4055.104. AUTHORITY OF CREDIT INSURANCE AGENT

Sec. 4055.105. EXEMPTION FROM CERTAIN DISCLOSURE

REQUIREMENTS

[Sections 4055.106-4055.150 reserved for expansion]

SUBCHAPTER D. TRAVEL INSURANCE LICENSE

Sec. 4055.151. DEFINITIONS

Sec. 4055.152. ISSUANCE OF LICENSE

Sec. 4055.153. AUTHORITY OF TRAVEL AGENCY OR FRANCHISEE

[Sections 4055.154-4055.200 reserved for expansion]

SUBCHAPTER E. SELF-SERVICE STORAGE FACILITY LICENSE

Sec. 4055.201. DEFINITIONS

Sec. 4055.202. ISSUANCE OF LICENSE

Sec. 4055.203. AUTHORITY OF SELF-SERVICE STORAGE FACILITY

OR FRANCHISEE

[Sections 4055.204-4055.250 reserved for expansion]

SUBCHAPTER F. TELECOMMUNICATIONS EQUIPMENT VENDOR LICENSE

Sec. 4055.251. DEFINITIONS

Sec. 4055.252. ISSUANCE OF LICENSE

Sec. 4055.253. AUTHORITY OF RETAIL VENDOR OF

TELECOMMUNICATIONS EQUIPMENT

CHAPTER 4055. SPECIALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4055.001. DEFINITION. In this chapter, "specialty license holder" means a person who holds a license issued under this chapter. (V.T.I.C. Art. 21.09, Sec. 1(a) (part).)

Sec. 4055.002. APPLICABILITY OF CHAPTER TO CERTAIN AGENTS.

(a) A person who holds a general property and casualty license issued under Chapter 4051 or a general life, accident, and health license issued under Chapter 4054 or who holds a substantially equivalent license under this code, as determined by the commissioner, is not required to obtain a specialty license.

(b) A person described by Subsection (a) is subject to the other requirements of this chapter in the solicitation, sale, or delivery of an insurance product that is subject to this chapter. (V.T.I.C. Art. 21.09, Sec. 1(j).)

Sec. 4055.003. RULES. The commissioner may adopt rules necessary to implement this chapter and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.09, Sec. 1(a) (part).)

Sec. 4055.004. APPLICATION. To obtain a specialty license an applicant must:

(1) submit to the commissioner:

(A) a written application:

(i) signed by the applicant;

(ii) on a form and supplements to the form prescribed by the commissioner; and

(iii) containing the information prescribed by the commissioner;

1 (B) a certification by an insurer authorized to
2 engage in business in this state:

3 (i) signed and sworn to by an officer of the
4 insurer;

5 (ii) stating that the insurer is satisfied
6 that the applicant is trustworthy and competent to act as the
7 insurer's agent for a limited purpose authorized by this chapter;
8 and

9 (iii) stating that if the specialty license
10 applied for is issued by the department the insurer will appoint the
11 applicant to act as an agent for a kind of insurance that is subject
12 to this chapter; and

13 (C) a nonrefundable license fee set by the
14 department in an amount necessary to administer this chapter; and

15 (2) comply with the other requirements of this
16 chapter. (V.T.I.C. Art. 21.09, Sec. 1(b).)

17 Sec. 4055.005. LICENSE ISSUANCE. The commissioner may
18 issue a specialty license to an applicant who complies with Section
19 4055.004 and the other requirements of this chapter. (V.T.I.C.
20 Art. 21.09, Sec. 1(a) (part).)

21 Sec. 4055.006. EXAMINATION AND CONTINUING EDUCATION NOT
22 REQUIRED. (a) An examination is not required for issuance of a
23 specialty license.

24 (b) A person is not required to comply with continuing
25 education requirements to hold a specialty license. (V.T.I.C. Art.
26 21.09, Sec. 1(1).)

27 Sec. 4055.007. APPOINTMENT AS AGENT BY INSURER. An insurer

1 that appoints an agent under this chapter shall:

2 (1) submit a certification of the appointment signed
3 by an officer of the insurer; and

4 (2) affirm that the insurer is satisfied that the
5 specialty license holder is trustworthy and competent to act as an
6 agent on behalf of the insurer. (V.T.I.C. Art. 21.09, Sec. 1(k).)

7 Sec. 4055.008. GENERAL POWERS AND DUTIES. (a) A specialty
8 license holder may act as an agent for the kinds of insurance that
9 are subject to this chapter for any insurer authorized to engage in
10 the business of those kinds of insurance in this state.

11 (b) Except as otherwise provided by this chapter, a
12 specialty license holder acting under this chapter shall comply
13 with this title. (V.T.I.C. Art. 21.09, Sec. 1(a) (part), (e).)

14 Sec. 4055.009. CERTAIN REPRESENTATIONS PROHIBITED. A
15 specialty license holder may not advertise, represent, or otherwise
16 hold out the license holder or an employee of the license holder as
17 an agent licensed under another chapter unless the entity or
18 individual holds the applicable license. (V.T.I.C. Art. 21.09,
19 Sec. 1(i).)

20 Sec. 4055.010. TREATMENT OF CERTAIN PREMIUMS.
21 Notwithstanding any other provision of this title or any rule
22 adopted by the commissioner, a specialty license holder is not
23 required to treat as money received in a fiduciary capacity
24 premiums collected from a consumer who purchases insurance coverage
25 when completing a consumer transaction associated with the coverage
26 if:

27 (1) the insurer represented by the license holder has

1 consented in writing, signed by an officer of the insurer, that
2 premiums are not required to be segregated from money received by
3 the license holder because of the consumer transaction associated
4 with the insurance coverage; and

5 (2) the charges for insurance coverage are itemized
6 but not billed to the consumer separately from the charges for the
7 associated consumer transaction. (V.T.I.C. Art. 21.09, Sec. 1(f).)

8 Sec. 4055.011. AUTHORITY OF EMPLOYEE OF SPECIALTY LICENSE
9 HOLDER. An employee of a specialty license holder may act as an
10 agent with respect to the kinds of insurance the license holder is
11 authorized to offer under this chapter only if the employee:

12 (1) is trained under Section 4055.012 to act
13 individually on behalf of the license holder;

14 (2) acts on behalf of and under the supervision of the
15 license holder; and

16 (3) is not compensated based primarily on the amount
17 of insurance sold by the employee under this chapter. (V.T.I.C.
18 Art. 21.09, Sec. 1(c).)

19 Sec. 4055.012. TRAINING REQUIRED TO ACT ON BEHALF OF
20 SPECIALTY LICENSE HOLDER. (a) A specialty license holder may not
21 allow an individual to act on the license holder's behalf with
22 respect to a kind of insurance that the license holder is authorized
23 to offer unless the individual has completed an approved training
24 program.

25 (b) The materials for the training program must be provided
26 to the specialty license holder by an insurer that writes the kind
27 of insurance authorized under the specialty license.

1 (c) An insurer that provides training program materials
2 under Subsection (b) must submit the training program to the
3 commissioner for approval before the training program is used.

4 (d) The training program must meet the following minimum
5 standards:

6 (1) each trainee must receive basic instruction about
7 the kinds of insurance the specialty license holder is authorized
8 to offer for purchase by prospective consumers;

9 (2) each trainee must be instructed to inform a
10 prospective consumer that, except as may be specifically provided
11 by another law of this state or the United States, the purchase of
12 the kind of insurance offered is not required to complete the
13 associated consumer transaction; and

14 (3) each trainee must be instructed with respect to
15 the disclosures required to be made to consumers. (V.T.I.C. Art.
16 21.09, Sec. 1(d).)

17 Sec. 4055.013. ASSIGNMENT AND TRANSFER OF COMPENSATION BY
18 CERTAIN AGENTS. A person who is licensed as a general life,
19 accident, and health agent or as a general property and casualty
20 agent or who holds a substantially equivalent license under this
21 code, as determined by the commissioner, and who enters into a
22 contract with an insurer to act as the insurer's agent in soliciting
23 or writing policies or certificates of insurance that are subject
24 to this chapter may assign and transfer to the agent's employer any
25 commission, fee, or other compensation to be paid to the agent under
26 the agent's contract with the insurer only if the sale of the
27 insurance product occurs within the scope of the agent's

1 employment. (V.T.I.C. Art. 21.09, Sec. 1(m).)

2 Sec. 4055.014. DISCLOSURES REQUIRED BEFORE ISSUANCE OF
3 INSURANCE. Except as provided by Section 4055.105, insurance
4 coverage may not be issued under this chapter unless:

5 (1) at each location at which sales of the coverage
6 occur, brochures or other written materials are prominently
7 displayed and readily available to a prospective consumer that:

8 (A) summarize, clearly and correctly, the
9 material terms of the coverage offered to consumers, including the
10 identity of the insurer;

11 (B) disclose that the coverage offered by the
12 specialty license holder may duplicate coverage already provided by
13 a consumer's personal auto insurance policy, homeowner's insurance
14 policy, personal liability insurance policy, or another source of
15 coverage;

16 (C) state that, except as specifically provided
17 by another law of this state or the United States, the purchase by
18 the consumer of the kind of insurance offered is not required to
19 complete the associated consumer transaction;

20 (D) describe the process for filing a claim for
21 benefits; and

22 (E) contain any additional information required
23 by the commissioner by rule regarding the price, benefits,
24 exclusions, conditions, or other limitations of the coverage; and

25 (2) evidence of coverage is provided to each consumer
26 who purchases the coverage. (V.T.I.C. Art. 21.09, Secs. 1(g), 2(d)
27 (part), 4(d), 5(d), 7(d).)

1 Sec. 4055.015. VIOLATION BY SPECIALTY LICENSE HOLDER;
2 PENALTIES. If a specialty license holder violates this title, the
3 commissioner may:

4 (1) impose any disciplinary action authorized by
5 Subchapter C, Chapter 4005; or

6 (2) after notice and opportunity for hearing, impose
7 other penalties, including suspending the transaction of insurance
8 at specific locations where a violation of this title has occurred,
9 as the commissioner considers necessary or appropriate to implement
10 the purposes of this title. (V.T.I.C. Art. 21.09, Sec. 1(h).)

11 [Sections 4055.016-4055.050 reserved for expansion]

12 SUBCHAPTER B. RENTAL CAR COMPANY LICENSE

13 Sec. 4055.051. DEFINITIONS. In this subchapter:

14 (1) "Rental agreement" means a written agreement that
15 states the terms and conditions governing the use of a vehicle or
16 vehicle equipment provided by a rental car company.

17 (2) "Rental car company" means a person engaged in the
18 business of providing leased or rented vehicles or vehicle
19 equipment to the public.

20 (3) "Renter" means a person who obtains the use of a
21 vehicle or vehicle equipment from a rental car company under the
22 terms of a rental agreement.

23 (4) "Vehicle" means:

24 (A) a private passenger motor vehicle, including
25 passenger vans and minivans that are primarily intended for the
26 transport of persons;

27 (B) a motor home;

1 (C) a motorcycle;

2 (D) a trailer with a gross vehicle weight rating
3 of 10,000 pounds or less; or

4 (E) a truck with a gross vehicle weight rating of
5 26,000 pounds or less and the operation of which does not require a
6 commercial driver's license.

7 (5) "Vehicle equipment" means a cartop carrier, tow
8 bar, or tow dolly specifically designed for use with a vehicle.
9 (V.T.I.C. Art. 21.09, Sec. 2(a).)

10 Sec. 4055.052. ISSUANCE OF LICENSE. Notwithstanding any
11 other provision of this chapter or this code, the commissioner
12 shall issue a specialty license to a rental car company, or to the
13 franchisee of a rental car company, that complies with this
14 subchapter. The specialty license may be issued only for the
15 limited purposes specified by this subchapter. (V.T.I.C. Art.
16 21.09, Sec. 2(b).)

17 Sec. 4055.053. AUTHORITY OF RENTAL CAR COMPANY OR
18 FRANCHISEE. (a) A rental car company or franchisee licensed under
19 this chapter may act as an agent for an authorized insurer only:

20 (1) in connection with the rental of vehicles or
21 vehicle equipment; and

22 (2) with respect to:

23 (A) excess liability insurance that provides
24 coverage in excess of the standard liability limits provided by the
25 rental car company in the rental agreement to the rental car company
26 or franchisee and to renters and other authorized drivers of rental
27 vehicles for liability arising from the negligent operation or use

1 of the rental vehicle or vehicle equipment;

2 (B) accident and health insurance that provides
3 coverage to renters and other rental vehicle occupants for
4 accidental death or dismemberment and for medical expenses
5 resulting from an accident involving the vehicle or vehicle
6 equipment that occurs during the rental period;

7 (C) personal effects insurance that provides
8 coverage to renters and other rental vehicle occupants for the loss
9 of or damage to personal effects or household belongings that
10 occurs during the rental period; or

11 (D) any other coverage the commissioner approves
12 as meaningful and appropriate in connection with the rental of
13 vehicles or vehicle equipment.

14 (b) A rental car company or franchisee licensed under this
15 chapter may not issue insurance under this subchapter in connection
16 with a rental agreement if the rental period under the agreement
17 exceeds 30 consecutive days. (V.T.I.C. Art. 21.09, Secs. 2(c), (d)
18 (part).)

19 [Sections 4055.054-4055.100 reserved for expansion]

20 SUBCHAPTER C. CREDIT INSURANCE LICENSE

21 Sec. 4055.101. GENERAL DEFINITIONS. In this subchapter:

22 (1) "Credit insurance" includes:

23 (A) credit life insurance;

24 (B) credit accident and health insurance;

25 (C) credit property insurance;

26 (D) credit involuntary unemployment insurance;

27 and

1 (E) insurance that covers the difference between
2 the actual cash value of a motor vehicle used as security for a loan
3 or lease and the outstanding balance of that loan or lease if loss
4 or damage renders the vehicle an actual or constructive total loss
5 while the debt for which the vehicle serves as security exceeds the
6 actual cash value of the vehicle.

7 (2) "Credit insurance agent" means a person licensed
8 under this chapter to sell credit insurance as specifically
9 provided by this subchapter. (V.T.I.C. Art. 21.09, Secs. 3(a)(1),
10 (2).)

11 Sec. 4055.102. DEFINITION OF CREDIT PROPERTY INSURANCE.

12 (a) In this subchapter, "credit property insurance" means
13 insurance that covers personal property:

14 (1) used as security for a personal or consumer loan;
15 or

16 (2) under an installment sales agreement or through a
17 consumer credit transaction that is purchased in connection with or
18 in relation to the personal or consumer loan, installment sale, or
19 consumer credit transaction.

20 (b) "Credit property insurance" does not include insurance
21 that:

22 (1) provides theft, collision, liability, property
23 damage, or comprehensive insurance coverage on an automobile,
24 motorized aircraft, motorcycle, truck, truck-tractor, traction
25 engine, or any other self-propelled vehicle or craft that is
26 designed primarily for operation in the air, or on highways,
27 roadways, waterways, or the sea, and the operating equipment of the

1 self-propelled vehicle or craft; or

2 (2) is necessary because of liability imposed by law
3 for damages arising out of the ownership, operation, maintenance,
4 or use of a vehicle or craft described by Subdivision (1), other
5 than single interest coverage on any vehicle or craft described by
6 Subdivision (1) that insures the interest of the creditor in the
7 same manner as security for a loan. (V.T.I.C. Art. 21.09, Sec.
8 3(a)(3).)

9 Sec. 4055.103. ISSUANCE OF LICENSE. Notwithstanding any
10 other provision of this chapter or this code, the commissioner may
11 issue a specialty license to a retail distributor of goods, an
12 automobile dealer, a bank, a state or federal savings and loan, a
13 state or federal credit union, a finance company, a production
14 credit association, a manufactured home retailer, or a mobile home
15 retailer that complies with this subchapter. The specialty license
16 may be issued only for the limited purposes specified by this
17 subchapter. (V.T.I.C. Art. 21.09, Sec. 3(b).)

18 Sec. 4055.104. AUTHORITY OF CREDIT INSURANCE AGENT. A
19 credit insurance agent appointed by an insurer authorized to engage
20 in the business of insurance under this code may act as the agent
21 for the insurer in the sale of any kind of credit insurance in the
22 business of which the insurer is authorized to engage, including
23 individual or group credit insurance. (V.T.I.C. Art. 21.09, Sec.
24 3(c).)

25 Sec. 4055.105. EXEMPTION FROM CERTAIN DISCLOSURE
26 REQUIREMENTS. A specialty license holder and the license holder's
27 representative are not required to make the disclosures required by

1 Section 4055.014 as that section relates to the sale or delivery of
2 a credit insurance product that is subject to this subchapter if the
3 license holder or representative complies with all disclosure
4 requirements prescribed by another provision of this code or
5 another law of this state or the United States with regard to the
6 sale or delivery of that product. (V.T.I.C. Art. 21.09, Sec. 3(d).)

7 [Sections 4055.106-4055.150 reserved for expansion]

8 SUBCHAPTER D. TRAVEL INSURANCE LICENSE

9 Sec. 4055.151. DEFINITIONS. In this subchapter:

10 (1) "Planned trip" means any journey or travel
11 arranged through the services of a travel agency.

12 (2) "Travel agency" means an entity engaged in the
13 business of selling or arranging transportation or accommodations
14 for the public.

15 (3) "Traveler" means an individual who seeks the
16 assistance of a travel agency in connection with the planning and
17 purchase of a trip. (V.T.I.C. Art. 21.09, Sec. 4(a).)

18 Sec. 4055.152. ISSUANCE OF LICENSE. Notwithstanding any
19 other provision of this chapter or this code, the commissioner may
20 issue a specialty license to a travel agency, the franchisee of a
21 travel agency, or a public carrier that complies with this
22 subchapter. The specialty license may be issued only for the
23 limited purposes specified by this subchapter. (V.T.I.C. Art.
24 21.09, Sec. 4(b).)

25 Sec. 4055.153. AUTHORITY OF TRAVEL AGENCY OR FRANCHISEE. A
26 travel agency or franchisee licensed under this chapter may act as
27 an agent for an authorized insurer only:

1 (1) in connection with the sale or arrangement of
2 transportation or accommodations for travelers; and

3 (2) with respect to:

4 (A) accident and health insurance that provides
5 coverage to a traveler for accidental death or dismemberment and
6 for medical expenses resulting from an accident involving the
7 traveler that occurs during the planned trip;

8 (B) insurance that provides coverage to a
9 traveler for expenses incurred as a result of trip cancellation or
10 interruption of a planned trip;

11 (C) personal effects insurance that provides
12 coverage to a traveler for loss of or damage to personal effects
13 during the planned trip;

14 (D) life insurance not exceeding \$150,000 on any
15 one life covering risks of travel during a planned trip; or

16 (E) any other coverage the commissioner approves
17 as meaningful and appropriate in connection with the transportation
18 or accommodations arranged through a travel agency. (V.T.I.C. Art.
19 21.09, Sec. 4(c).)

20 [Sections 4055.154-4055.200 reserved for expansion]

21 SUBCHAPTER E. SELF-SERVICE STORAGE FACILITY LICENSE

22 Sec. 4055.201. DEFINITIONS. In this subchapter:

23 (1) "Rental agreement" means a written agreement that
24 states the terms governing the use of storage space provided by a
25 self-service storage facility.

26 (2) "Renter" means a person who obtains the use of
27 storage space from a self-service storage facility under a rental

1 agreement.

2 (3) "Self-service storage facility" means a person
3 engaged in the business of providing leased or rented storage space
4 to the public.

5 (4) "Storage space" means a room, unit, locker, or
6 open space offered for rental to the public for temporary storage of
7 personal belongings or light commercial goods. (V.T.I.C. Art.
8 21.09, Sec. 5(a).)

9 Sec. 4055.202. ISSUANCE OF LICENSE. Notwithstanding any
10 other provision of this chapter or this code, the commissioner may
11 issue a specialty license to a self-service storage facility or to
12 the franchisee of a self-service storage facility that complies
13 with this subchapter. The specialty license may be issued only for
14 the limited purposes specified by this subchapter. (V.T.I.C. Art.
15 21.09, Sec. 5(b).)

16 Sec. 4055.203. AUTHORITY OF SELF-SERVICE STORAGE FACILITY
17 OR FRANCHISEE. A self-service storage facility or franchisee
18 licensed under this chapter may act as an agent for any authorized
19 insurer only:

20 (1) in connection with the rental of storage space;
21 and

22 (2) with respect to:

23 (A) hazard insurance coverage provided to a
24 renter for loss of or damage to tangible personal property in
25 storage or in transit during the rental period; or

26 (B) any other coverage the commissioner approves
27 as meaningful and appropriate in connection with the rental of

1 storage space. (V.T.I.C. Art. 21.09, Sec. 5(c).)

2 [Sections 4055.204-4055.250 reserved for expansion]

3 SUBCHAPTER F. TELECOMMUNICATIONS EQUIPMENT VENDOR LICENSE

4 Sec. 4055.251. DEFINITIONS. In this subchapter:

5 (1) "Customer" means a person who purchases
6 telecommunications equipment in a retail sales transaction.

7 (2) "Telecommunications equipment" includes handsets,
8 pagers, automatic answering devices, batteries, and other devices
9 used to originate or receive wireless communications exclusive of
10 cordless, wireline communications. (V.T.I.C. Art. 21.09, Sec.
11 7(a).)

12 Sec. 4055.252. ISSUANCE OF LICENSE. Notwithstanding any
13 other provision of this chapter or this code, the commissioner may
14 issue a specialty license to a retail vendor of telecommunications
15 equipment who complies with this subchapter. The specialty license
16 may be issued only for the limited purposes specified by this
17 subchapter. (V.T.I.C. Art. 21.09, Sec. 7(b).)

18 Sec. 4055.253. AUTHORITY OF RETAIL VENDOR OF
19 TELECOMMUNICATIONS EQUIPMENT. A retail vendor of
20 telecommunications equipment licensed under this chapter may act as
21 an agent for an authorized insurer only:

22 (1) in connection with the sale and use of
23 telecommunications equipment; and

24 (2) with respect to:

25 (A) insurance coverage provided to customers for
26 the loss or malfunction of or damage to telecommunications
27 equipment; or

(B) any other coverage the commissioner approves as meaningful and appropriate in connection with the use of telecommunications equipment. (V.T.I.C. Art. 21.09, Sec. 7(c).)

CHAPTER 4056. NONRESIDENT AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4056.001. APPLICABILITY OF TITLE

Sec. 4056.002. RIGHTS OF LICENSE HOLDERS

Sec. 4056.003. RECIPROCAL LICENSING AGREEMENTS

Sec. 4056.004. HOME OFFICE EMPLOYEES

Sec. 4056.005. RULES

[Sections 4056.006-4056.050 reserved for expansion]

SUBCHAPTER B. NONRESIDENT AGENT LICENSE

Sec. 4056.051. APPLICATION FOR NONRESIDENT AGENT LICENSE;
CRIMINAL HISTORY

Sec. 4056.052. ISSUANCE OF LICENSE TO NONRESIDENT
AGENT LICENSED IN OTHER STATE

Sec. 4056.053. ISSUANCE OF LICENSE TO NONRESIDENT AGENT
NOT LICENSED IN OTHER STATE

Sec. 4056.054. ISSUANCE OF LICENSE TO CORPORATION OR
PARTNERSHIP

Sec. 4056.055. WAIVER OF REQUIREMENTS FOR NONRESIDENT
AGENT LICENSED IN OTHER STATE
OR JURISDICTION

Sec. 4056.056. RESTRICTIONS ON LINE OF INSURANCE
BUSINESS FOR RECIPROCAL NONRESIDENT
AGENT LICENSE

Sec. 4056.057. CONTINUING EDUCATION

1 Sec. 4056.058. SERVICE OF PROCESS

2 CHAPTER 4056. NONRESIDENT AGENTS

3 SUBCHAPTER A. GENERAL PROVISIONS

4 Sec. 4056.001. APPLICABILITY OF TITLE. This title applies
5 to licensing of a nonresident agent under this chapter. (V.T.I.C.
6 Art. 21.11, Sec. 3(c).)

7 Sec. 4056.002. RIGHTS OF LICENSE HOLDERS. Except as
8 otherwise specifically provided by this code, an individual who is
9 not a resident of this state and to whom a license is issued under
10 this chapter has the same rights and privileges as a resident
11 license holder. (V.T.I.C. Art. 21.11, Sec. 2(a).)

12 Sec. 4056.003. RECIPROCAL LICENSING AGREEMENTS. The
13 commissioner may enter into an agreement with the appropriate
14 official of another state as necessary to implement reciprocal
15 licensing of nonresident agents. (V.T.I.C. Art. 21.11, Sec. 1(b).)

16 Sec. 4056.004. HOME OFFICE EMPLOYEES. This chapter does
17 not affect the authority established under Subchapter G, Chapter
18 4051, of a full-time home office salaried employee of an insurer
19 authorized to engage in the business of insurance in this state.
20 (V.T.I.C. Art. 21.11, Sec. 4.)

21 Sec. 4056.005. RULES. The commissioner may adopt rules as
22 necessary to implement this subchapter and Subchapter B and to meet
23 the minimum requirements of federal law, including regulations.
24 (V.T.I.C. Art. 21.11, Sec. 5.)

25 [Sections 4056.006-4056.050 reserved for expansion]

26 SUBCHAPTER B. NONRESIDENT AGENT LICENSE

27 Sec. 4056.051. APPLICATION FOR NONRESIDENT AGENT LICENSE;

1 CRIMINAL HISTORY. (a) To apply for a license to act as a
2 nonresident agent, a person who is not a resident of this state must
3 submit to the department:

4 (1) an application on a form prescribed by the
5 department; and

6 (2) the nonrefundable license application fee.

7 (b) An applicant who does not hold an insurance agent's
8 license in the applicant's state of residence must, through the law
9 enforcement agency of the state of residence, submit to the
10 department a copy of the applicant's criminal history records. The
11 department shall use the criminal history records to determine the
12 applicant's eligibility for issuance of a license in accordance
13 with this title and other laws of this state. (V.T.I.C. Art. 21.11,
14 Secs. 1(a) (part), (e).)

15 Sec. 4056.052. ISSUANCE OF LICENSE TO NONRESIDENT AGENT
16 LICENSED IN OTHER STATE. (a) The department shall issue a license
17 to an applicant under this chapter if:

18 (1) the applicant holds a license in good standing as
19 an agent in the applicant's state of residence; and

20 (2) the applicant's state of residence will grant a
21 nonresident agent license on a reciprocal basis to a resident agent
22 of this state.

23 (b) The department may issue a reciprocal nonresident agent
24 license to an applicant if the authority granted by the license
25 issued by the applicant's state of residence is generally
26 comparable to the authority granted by a license issued by this
27 state. (V.T.I.C. Art. 21.11, Secs. 1(a) (part), 3(a).)

1 Sec. 4056.053. ISSUANCE OF LICENSE TO NONRESIDENT AGENT NOT
2 LICENSED IN OTHER STATE. The department shall issue a license to an
3 applicant under this chapter if the applicant has:

4 (1) passed the examination for an agent's license
5 required under this title;

6 (2) met the eligibility requirements for issuance of a
7 license after an examination of the applicant's criminal history
8 records under Section 4056.051(b); and

9 (3) satisfied the requirements for a license for an
10 individual under this code, including Subchapter C, Chapter 4001.
11 (V.T.I.C. Art. 21.11, Sec. 1(a) (part).)

12 Sec. 4056.054. ISSUANCE OF LICENSE TO CORPORATION OR
13 PARTNERSHIP. The department shall issue a license to an applicant
14 under this chapter if the applicant has satisfied the requirements
15 for a license for a corporation or partnership under Subchapter C,
16 Chapter 4001. (V.T.I.C. Art. 21.11, Sec. 1(a) (part).)

17 Sec. 4056.055. WAIVER OF REQUIREMENTS FOR NONRESIDENT AGENT
18 LICENSED IN OTHER STATE OR JURISDICTION. The department may waive
19 any license requirement for an applicant who holds a valid license
20 from another state or jurisdiction if:

21 (1) that state or jurisdiction has license
22 requirements substantially equivalent to those of this state; or

23 (2) the waiver is necessary to promote reciprocal
24 licensing of nonresident agents among a majority of the states.
25 (V.T.I.C. Art. 21.11, Sec. 1(c).)

26 Sec. 4056.056. RESTRICTIONS ON LINE OF INSURANCE BUSINESS
27 FOR RECIPROCAL NONRESIDENT AGENT LICENSE. A nonresident agent

1 licensed under Section 4056.052 may not act as a nonresident agent
2 for a line of insurance business in this state unless the agent is
3 authorized in the agent's state of residence to act in that state as
4 an agent for that line of insurance business. (V.T.I.C. Art. 21.11,
5 Sec. 3(b).)

6 Sec. 4056.057. CONTINUING EDUCATION. (a) The continuing
7 education requirements imposed under Chapter 4004 do not apply to a
8 person who:

9 (1) holds a license issued under this chapter; and
10 (2) is in compliance with the continuing education
11 requirements of the person's state of residence.

12 (b) A person who holds a license issued under this chapter
13 and who does not hold an insurance agent's license in the person's
14 state of residence shall comply with the continuing education
15 requirements imposed under Chapter 4004. (V.T.I.C. Art. 21.11,
16 Secs. 2(b), (c).)

17 Sec. 4056.058. SERVICE OF PROCESS. The commissioner is the
18 agent for service of process in the manner provided by Subchapter C,
19 Chapter 804, in a legal proceeding against a nonresident agent who
20 holds a license issued under this chapter if:

21 (1) the nonresident agent does not appoint or maintain
22 an agent for service in this state;

23 (2) an agent for service is appointed but cannot with
24 reasonable diligence be found; or

25 (3) the license of the nonresident agent is revoked.
26 (V.T.I.C. Art. 21.11, Sec. 1(d).)

27 [Chapters 4057-4100 reserved for expansion]

SUBTITLE C. ADJUSTERS

CHAPTER 4101. INSURANCE ADJUSTERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4101.001. DEFINITIONS

Sec. 4101.002. GENERAL EXEMPTIONS

Sec. 4101.003. TEMPORARY EXEMPTION

Sec. 4101.004. RECIPROCITY

Sec. 4101.005. RULES

Sec. 4101.006. ADVISORY BOARD

[Sections 4101.007-4101.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4101.051. LICENSE REQUIRED

Sec. 4101.052. APPLICATION

Sec. 4101.053. QUALIFICATIONS; ISSUANCE

Sec. 4101.054. EXAMINATION REQUIRED

Sec. 4101.055. EXAMINATION PROCEDURES

Sec. 4101.056. EXEMPTION FROM EXAMINATION REQUIREMENT

Sec. 4101.057. FEES

Sec. 4101.058. LICENSE FORM

Sec. 4101.059. CONTINUING EDUCATION: GENERAL REQUIREMENTS

Sec. 4101.060. CONTINUING EDUCATION: EXEMPTIONS AND

WAIVERS

Sec. 4101.061. EXPIRATION; RENEWAL

[Sections 4101.062-4101.100 reserved for expansion]

SUBCHAPTER C. SPECIAL LICENSES

Sec. 4101.101. EMERGENCY LICENSE

Sec. 4101.102. LIMITED LICENSE

[Sections 4101.103-4101.150 reserved for expansion]

SUBCHAPTER D. POWERS AND DUTIES OF ADJUSTER

Sec. 4101.151. PLACE OF BUSINESS

Sec. 4101.152. REFERRAL BY INSURER

[Sections 4101.153-4101.200 reserved for expansion]

SUBCHAPTER E. ENFORCEMENT

Sec. 4101.201. GROUNDS FOR DISCIPLINARY ACTION

Sec. 4101.202. REINSTATEMENT OR REISSUANCE OF LICENSE

Sec. 4101.203. CRIMINAL PENALTY

CHAPTER 4101. INSURANCE ADJUSTERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4101.001. DEFINITIONS. (a) In this chapter, "adjuster" means an individual who:

(1) investigates or adjusts losses on behalf of an insurer as an independent contractor or as an employee of:

(A) an adjustment bureau;

(B) an association;

(C) a general property and casualty agent;

(D) an independent contractor;

(E) an insurer; or

(F) a managing general agent; or

(2) supervises the handling of claims.

(b) For purposes of this chapter, "insurer" includes a self-insured. (V.T.I.C. Art. 21.07-4, Secs. 1(a), (c).)

Sec. 4101.002. GENERAL EXEMPTIONS. (a) This chapter does not apply to:

(1) an attorney who:

1 (A) adjusts insurance losses periodically and
2 incidentally to the practice of law; and

3 (B) does not represent that the attorney is an
4 adjuster;

5 (2) a salaried employee of an insurer who is not
6 regularly engaged in the adjustment, investigation, or supervision
7 of insurance claims;

8 (3) a person employed only to furnish technical
9 assistance to a licensed adjuster, including:

10 (A) an attorney;

11 (B) an engineer;

12 (C) an estimator;

13 (D) a handwriting expert;

14 (E) a photographer; and

15 (F) a private detective;

16 (4) an agent or general agent of an authorized insurer
17 who processes an undisputed or uncontested loss for the insurer
18 under a policy issued by the agent or general agent;

19 (5) a person who performs clerical duties and does not
20 negotiate with parties to disputed or contested claims;

21 (6) a person who handles claims arising under life,
22 accident, and health insurance policies;

23 (7) a person:

24 (A) who is employed principally as:

25 (i) a right-of-way agent; or

26 (ii) a right-of-way and claims agent;

27 (B) whose primary responsibility is the

1 acquisition of easements, leases, permits, or other real property
2 rights; and

3 (C) who handles only claims arising out of
4 operations under those easements, leases, permits, or other
5 contracts or contractual obligations; or

6 (8) an individual who is employed to investigate
7 suspected fraudulent insurance claims but who does not adjust
8 losses or determine claims payments.

9 (b) A nonresident adjuster is not required to hold a license
10 under this chapter to:

11 (1) adjust a single loss in this state;

12 (2) adjust losses arising out of a catastrophe common
13 to all those losses; or

14 (3) act as a temporary substitute for a licensed
15 adjuster. (V.T.I.C. Art. 21.07-4, Secs. 1(b), 2(a) (part).)

16 Sec. 4101.003. TEMPORARY EXEMPTION. An individual who is
17 undergoing training as an adjuster under the supervision of a
18 licensed adjuster may act as an adjuster for a period not to exceed
19 12 months without having a license issued under this chapter if, at
20 the beginning of the period, the individual has been registered
21 with the commissioner as a trainee. (V.T.I.C. Art. 21.07-4, Sec.
22 2(a) (part).)

23 Sec. 4101.004. RECIPROCITY. The department may waive any
24 license requirement imposed under this chapter for an applicant who
25 holds a valid license from another state if the state has license
26 requirements substantially equivalent to the requirements for a
27 license issued under this chapter. (V.T.I.C. Art. 21.07-4, Sec.

1 4.)

2 Sec. 4101.005. RULES. The commissioner may adopt rules
3 necessary to implement this chapter and to meet the minimum
4 requirements of federal law, including regulations. (V.T.I.C. Art.
5 21.07-4, Sec. 24.)

6 Sec. 4101.006. ADVISORY BOARD. (a) An advisory board shall
7 make recommendations to the commissioner regarding:

8 (1) the scope, time, and conduct of written
9 examinations under Subchapter B;

10 (2) the times and locations in this state where the
11 examinations are held; and

12 (3) any other matter the commissioner submits to the
13 advisory board for a recommendation.

14 (b) The advisory board is composed of nine members appointed
15 by the commissioner as follows:

16 (1) the presiding officer of the unauthorized practice
17 of law committee of the State Bar of Texas;

18 (2) three members who represent the public;

19 (3) two members with knowledge and experience in the
20 profession of insurance adjusting;

21 (4) one member from a domestic insurer authorized to
22 engage in business in this state;

23 (5) one member from a foreign insurer authorized to
24 engage in business in this state; and

25 (6) one member who is an independent adjuster.

26 (c) A member who represents the public may not be:

27 (1) an officer, director, or employee of:

1 (A) an adjuster;
2 (B) an agent;
3 (C) a broker;
4 (D) an insurance agency;
5 (E) an insurer; or
6 (F) any other business entity regulated by the
7 department;

8 (2) a person required to register as a lobbyist under
9 Chapter 305, Government Code; or

10 (3) a person related to a person described by
11 Subdivision (1) or (2) within the second degree of affinity or
12 consanguinity.

13 (d) A member of the advisory board serves without
14 compensation. If authorized by the commissioner, an advisory board
15 member is entitled to reimbursement for reasonable expenses
16 incurred in attending meetings of the advisory board. (V.T.I.C.
17 Art. 21.07-4, Sec. 9.)

18 [Sections 4101.007-4101.050 reserved for expansion]

19 SUBCHAPTER B. LICENSE REQUIREMENTS

20 Sec. 4101.051. LICENSE REQUIRED. Except as otherwise
21 provided by this chapter, a person may not act as or represent that
22 the person is an adjuster in this state unless the person holds a
23 license under this chapter. (V.T.I.C. Art. 21.07-4, Sec. 2(a)
24 (part).)

25 Sec. 4101.052. APPLICATION. (a) An applicant for a license
26 under this chapter must submit to the department an application on a
27 form prescribed and provided by the department, and include as part

1 of or in connection with the application any information that the
2 department reasonably requires, including information about the
3 applicant's:

- 4 (1) identity;
- 5 (2) personal history;
- 6 (3) experience; and
- 7 (4) business record.

8 (b) The application must be accompanied by the fee required
9 by Section 4101.057. (V.T.I.C. Art. 21.07-4, Secs. 3, 14(b).)

10 Sec. 4101.053. QUALIFICATIONS; ISSUANCE. (a) To qualify
11 for a license under this chapter, an applicant must:

- 12 (1) comply with this chapter;
- 13 (2) present evidence satisfactory to the department

14 that the applicant:

15 (A) is at least 18 years of age;

16 (B) resides in this state or a state or country
17 that permits a resident of this state to act as an adjuster in that
18 state or country;

19 (C) has complied with all federal laws relating
20 to employment or the transaction of business in the United States,
21 if the applicant does not reside in the United States;

22 (D) is trustworthy; and

23 (E) has had experience, special education, or
24 training of sufficient duration and extent regarding the handling
25 of loss claims under insurance contracts to make the applicant
26 competent to fulfill the responsibilities of an adjuster; and

- 27 (3) pass an examination conducted under this

1 subchapter or present evidence that the applicant has been exempted
2 under Section 4101.056.

3 (b) The commissioner shall issue a license to an applicant
4 who meets the qualifications prescribed by this section. (V.T.I.C.
5 Art. 21.07-4, Sec. 7.)

6 Sec. 4101.054. EXAMINATION REQUIRED. (a) To be eligible
7 for a license under this chapter, an applicant must personally take
8 and pass, to the satisfaction of the commissioner, a written
9 examination of the applicant's qualifications and competency.

10 (b) The department may supplement a written examination
11 under Subsection (a) with an oral examination.

12 (c) The commissioner shall prescribe each examination under
13 this section. An examination must be of sufficient scope to
14 reasonably test the applicant's knowledge relative to the kinds of
15 insurance that may be dealt with under the license and of:

16 (1) the duties of a licensed adjuster; and

17 (2) the laws of this state that apply to a licensed
18 adjuster.

19 (d) The commissioner may require a reasonable waiting
20 period before an applicant who fails to pass an examination is
21 eligible to be retested on a similar examination. (V.T.I.C. Art.
22 21.07-4, Secs. 10 (part), 11(a), 12(a), (c).)

23 Sec. 4101.055. EXAMINATION PROCEDURES. (a) The department
24 shall prepare and make available to applicants instructions
25 specifying in general terms the subjects that may be covered in an
26 examination required under Section 4101.054.

27 (b) An examination under this subchapter shall be given at

1 times and locations in this state necessary to reasonably serve the
2 convenience of the department and applicants. (V.T.I.C. Art.
3 21.07-4, Secs. 11(b), 12(b).)

4 Sec. 4101.056. EXEMPTION FROM EXAMINATION REQUIREMENT. (a)
5 An applicant for a license under this chapter is not required to
6 pass an examination under Section 4101.054 to receive the license
7 if the applicant:

8 (1) had been principally engaged in the investigation,
9 adjustment, or supervision of losses on August 27, 1973, and during
10 the 90-day period preceding that date;

11 (2) is applying for a renewal license under this
12 chapter;

13 (3) is licensed as an adjuster in another state with
14 which a reciprocal agreement has been entered into by the
15 commissioner; or

16 (4) has completed a course in adjusting losses as
17 prescribed and approved by the commissioner and it is certified to
18 the commissioner on completion of the course that the applicant
19 has:

20 (A) completed the course; and

21 (B) passed an examination testing the
22 applicant's knowledge and qualification, as prescribed by the
23 commissioner.

24 (b) An applicant wishing to claim an exemption under
25 Subsection (a)(4) is responsible for the scheduling and
26 administration of the examination required under that subsection.
27 (V.T.I.C. Art. 21.07-4, Secs. 10 (part), 12(d).)

1 Sec. 4101.057. FEES. (a) Before issuing or renewing a
2 license under this chapter, the department shall set and collect a
3 nonrefundable license fee in an amount not to exceed \$50.

4 (b) An applicant must remit the fee required by Subsection
5 (a) biennially after the issuance of the original license. If the
6 applicant's license has been expired for not more than 90 days, an
7 applicant for a renewal license must remit, in addition to the fee
8 assessed under Subsection (a), a fee equal to one-half of the
9 original license fee.

10 (c) Before administering an examination under this
11 subchapter, the department shall set and collect a nonrefundable
12 examination fee in an amount not to exceed \$50.

13 (d) Before issuing a duplicate license requested by an
14 adjuster, the department shall set and collect a duplicate license
15 fee.

16 (e) The department shall deposit a fee collected under this
17 chapter to the credit of the Texas Department of Insurance
18 operating account. (V.T.I.C. Art. 21.07-4, Secs. 14(a), (c), 23.)

19 Sec. 4101.058. LICENSE FORM. (a) The commissioner shall
20 prescribe the form of a license issued under this chapter.

21 (b) A license must contain:

22 (1) the adjuster's name;
23 (2) the address of the adjuster's place of business;
24 (3) the date of issuance and the date of expiration of
25 the license; and

26 (4) the name of the firm or insurer with whom the
27 adjuster is employed at the time the license is issued. (V.T.I.C.

1 Art. 21.07-4, Sec. 13.)

2 Sec. 4101.059. CONTINUING EDUCATION: GENERAL
3 REQUIREMENTS. (a) To renew a license under this chapter a licensed
4 adjuster must participate in a continuing education program
5 relating to consumer protection. The program must include
6 education relating to consumer protection laws, including:

- 7 (1) Chapter 541;
8 (2) Chapter 547;
9 (3) Subchapter A, Chapter 542;
10 (4) Subchapter E, Chapter 17, Business & Commerce
11 Code; and
12 (5) any other similar laws specified by the
13 department.

14 (b) The department may certify continuing education
15 programs. (V.T.I.C. Art. 21.07-4, Secs. 7A(a), (b).)

16 Sec. 4101.060. CONTINUING EDUCATION: EXEMPTIONS AND
17 WAIVERS. (a) On written request of a licensed adjuster and if the
18 department determines that the adjuster is unable to comply with
19 continuing education requirements under this subchapter because of
20 illness, medical disability, or another extenuating circumstance
21 beyond the control of the adjuster, the department may:

- 22 (1) extend the time for the adjuster to comply with the
23 continuing education requirements; or
24 (2) exempt the adjuster from any of the requirements
25 for a licensing period.

26 (b) The commissioner by rule shall establish the criteria
27 for an extension or exemption under Subsection (a).

1 (c) The department may waive any continuing education
2 requirement imposed under this chapter for a nonresident adjuster
3 who holds a valid license from another state if the state has
4 continuing education requirements substantially equivalent to the
5 requirements for a license issued under this chapter. (V.T.I.C.
6 Art. 21.07-4, Secs. 7A(c), (d).)

7 Sec. 4101.061. EXPIRATION; RENEWAL. Expiration and renewal
8 of a license issued under this chapter are governed by rules adopted
9 by the commissioner or any applicable provision of this code or
10 another insurance law of this state. (V.T.I.C. Art. 21.07-4, Sec.
11 16.)

12 [Sections 4101.062-4101.100 reserved for expansion]

13 SUBCHAPTER C. SPECIAL LICENSES

14 Sec. 4101.101. EMERGENCY LICENSE. (a) If a catastrophe or
15 an emergency arises out of a disaster, act of God, riot, civil
16 commotion, conflagration, or other similar occurrence, the
17 commissioner shall, on application, issue an emergency license to a
18 person if the application is certified to the commissioner not
19 later than the fifth day after the date on which the person begins
20 work as an adjuster by:

21 (1) a person who holds a license under this chapter; or
22 (2) an insurer that maintains an office in this state
23 and holds a certificate of authority to engage in the business of
24 insurance in this state.

25 (b) The person or insurer that certifies an application
26 under Subsection (a) is responsible for the loss or claims
27 practices of the emergency license holder whom the person or

1 insurer certifies.

2 (c) The commissioner may, after notice and hearing, revoke
3 an emergency license on grounds specified by Section 4101.201.

4 (d) An emergency license is effective for a period not to
5 exceed 90 days. The commissioner may extend the term of the
6 emergency license for an additional period of 90 days.

7 (e) The commissioner shall establish a fee for an emergency
8 license in an amount not to exceed \$20. A person issued an
9 emergency license shall remit the fee to the department not later
10 than the 30th day after the date on which the department issues the
11 license.

12 (f) The commissioner may issue an emergency license to an
13 applicant who meets the requirements of Subsection (a) regardless
14 of whether the applicant is:

15 (1) a resident of this state; or

16 (2) an otherwise licensed adjuster. (V.T.I.C. Art.
17 21.07-4, Sec. 5.)

18 Sec. 4101.102. LIMITED LICENSE. (a) If considered
19 necessary by the commissioner, the department may issue a limited
20 license to an applicant in the manner otherwise provided for the
21 issuance of a license under this chapter.

22 (b) The license shall specifically limit the kinds of
23 insurance that may be handled by the person.

24 (c) The person may not adjust claims in a kind of insurance
25 other than that for which the adjuster is specifically licensed.
26 (V.T.I.C. Art. 21.07-4, Secs. 8(a), (b), (c).)

27 [Sections 4101.103-4101.150 reserved for expansion]

SUBCHAPTER D. POWERS AND DUTIES OF ADJUSTER

Sec. 4101.151. PLACE OF BUSINESS. (a) A licensed adjuster shall maintain a place of business that is:

(1) located at the place at which the adjuster principally conducts transactions under the license; and

(2) accessible to the public.

(b) A licensed adjuster shall promptly notify the commissioner if the adjuster changes the location of the adjuster's place of business. (V.T.I.C. Art. 21.07-4, Sec. 15.)

Sec. 4101.152. REFERRAL BY INSURER. (a) An insurer may not knowingly refer a claim or loss for adjustment in this state to a person purporting to be or acting as an adjuster unless the person holds a license under this chapter.

(b) Before referring a claim or loss for adjustment, an insurer must ascertain from the commissioner whether the person performing the adjustment holds a license under this chapter. Once the insurer has ascertained that the person holds a license, the insurer may refer the claim or loss to the person and may continue to refer claims or losses to the person until the insurer has knowledge or receives information from the commissioner that the person no longer holds a license. (V.T.I.C. Art. 21.07-4, Sec. 6.)

[Sections 4101.153-4101.200 reserved for expansion]

SUBCHAPTER E. ENFORCEMENT

Sec. 4101.201. GROUNDS FOR DISCIPLINARY ACTION. (a) The commissioner may discipline an adjuster or deny an application for a license under this chapter under a department rule or any applicable insurance law of this state.

1 (b) Department rules may specify grounds for discipline
2 that are comparable to grounds for discipline of other license
3 holders under this title. (V.T.I.C. Art. 21.07-4, Sec. 17.)

4 Sec. 4101.202. REINSTATEMENT OR REISSUANCE OF LICENSE. The
5 commissioner may not reinstate or reissue the license of a license
6 holder or former license holder whose license has been suspended,
7 revoked, or refused renewal until the commissioner determines that
8 the cause for a suspension, revocation, or refusal of a license
9 issued under this chapter no longer exists. (V.T.I.C. Art.
10 21.07-4, Sec. 20.)

11 Sec. 4101.203. CRIMINAL PENALTY. A person commits an
12 offense if the person violates Section 4101.051 or 4101.102(c). An
13 offense under this section is a misdemeanor punishable by:

14 (1) a fine of not more than \$500;

15 (2) confinement in the county jail for not more than
16 six months; or

17 (3) both the fine and the confinement. (V.T.I.C. Art.
18 21.07-4, Secs. 2(b), 8(d).)

19 [Chapters 4102-4150 reserved for expansion]

20 SUBTITLE D. OTHER PROFESSIONALS

21 CHAPTER 4151. THIRD-PARTY ADMINISTRATORS

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Sec. 4151.001. DEFINITIONS

24 Sec. 4151.002. EXEMPTIONS

25 Sec. 4151.003. APPLICABILITY OF OTHER PROVISIONS OF CODE

26 Sec. 4151.004. APPLICABILITY TO CERTAIN INSURERS

27 AND HEALTH MAINTENANCE ORGANIZATIONS

1 Sec. 4151.005. ADMINISTRATOR NOT INSURANCE AGENT

2 Sec. 4151.006. RULES

3 [Sections 4151.007-4151.050 reserved for expansion]

4 SUBCHAPTER B. CERTIFICATE OF AUTHORITY

5 Sec. 4151.051. CERTIFICATE OF AUTHORITY REQUIRED

6 Sec. 4151.052. APPLICATION

7 Sec. 4151.053. APPROVAL OF APPLICATION

8 Sec. 4151.054. DENIAL OF APPLICATION

9 Sec. 4151.055. FIDELITY BOND REQUIRED

10 Sec. 4151.056. DURATION OF CERTIFICATE OF AUTHORITY

11 [Sections 4151.057-4151.100 reserved for expansion]

12 SUBCHAPTER C. POWERS AND DUTIES OF

13 THIRD-PARTY ADMINISTRATORS

14 Sec. 4151.101. WRITTEN AGREEMENT WITH INSURER

15 OR PLAN SPONSOR REQUIRED

16 Sec. 4151.102. CONTENTS OF WRITTEN AGREEMENT

17 Sec. 4151.103. RETENTION OF WRITTEN AGREEMENT;

18 INSPECTION BY COMMISSIONER

19 Sec. 4151.104. NOTICE OF USE OF ADMINISTRATOR'S SERVICES

20 Sec. 4151.105. PAYMENTS TO ADMINISTRATOR

21 Sec. 4151.106. CERTAIN FUNDS COLLECTED OR RECEIVED

22 BY ADMINISTRATOR

23 Sec. 4151.107. DELIVERY OR DEPOSIT OF CERTAIN FUNDS

24 RECEIVED BY ADMINISTRATOR

25 Sec. 4151.108. WITHDRAWALS FROM FIDUCIARY ACCOUNT

26 Sec. 4151.109. PAYMENT OF CLAIMS FROM FIDUCIARY

27 ACCOUNT PROHIBITED

1 Sec. 4151.110. UNDERWRITING STANDARDS

2 Sec. 4151.111. ADJUDICATION OF CLAIMS

3 Sec. 4151.112. MAINTENANCE OF BOOKS AND RECORDS

4 Sec. 4151.113. ACCESS TO BOOKS AND RECORDS

5 Sec. 4151.114. DISPOSITION OF BOOKS AND RECORDS ON

6 TERMINATION OF WRITTEN AGREEMENT

7 Sec. 4151.115. CONFIDENTIALITY OF PERSONAL INFORMATION

8 Sec. 4151.116. ADVERTISING

9 Sec. 4151.117. COMPENSATION OF ADMINISTRATOR

10 [Sections 4151.118-4151.150 reserved for expansion]

11 SUBCHAPTER D. PHARMACY BENEFIT PLANS

12 Sec. 4151.151. DEFINITION

13 Sec. 4151.152. IDENTIFICATION CARDS

14 Sec. 4151.153. DISCLOSURE OF CERTAIN PATIENT

15 INFORMATION PROHIBITED

16 [Sections 4151.154-4151.200 reserved for expansion]

17 SUBCHAPTER E. REGULATION OF

18 THIRD-PARTY ADMINISTRATORS

19 Sec. 4151.201. EXAMINATION OF ADMINISTRATOR

20 Sec. 4151.202. CONTENTS OF EXAMINATION;

21 ON-SITE EVALUATION

22 Sec. 4151.203. COST OF EXAMINATION

23 Sec. 4151.204. EXAMINATION UNDER OATH

24 Sec. 4151.205. ANNUAL REPORT

25 Sec. 4151.206. FEES

26 Sec. 4151.207. ADMINISTRATIVE SANCTIONS

27 Sec. 4151.208. OFFENSE

CHAPTER 4151. THIRD-PARTY ADMINISTRATORS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4151.001. DEFINITIONS. In this chapter:

(1) "Administrator" means a person who, in connection with annuities or life, health, and accident benefits, including pharmacy benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. The term does not include a person described by Section 4151.002.

(2) "Insurer" means a person who engages in the business of life, health, or accident insurance under the law of this state.

(3) "Person" means an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity.

(4) "Plan" means a plan, fund, or program established, adopted, or maintained by a plan sponsor or insurer to the extent that the plan, fund, or program is established, adopted, or maintained to provide indemnification or expense reimbursement for any type of life, health, or accident benefit.

(5) "Plan sponsor" means a person, other than an insurer, who establishes, adopts, or maintains a plan that covers residents of this state, including a plan established, adopted, or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

1 (V.T.I.C. Art. 21.07-6, Secs. 1(1) (part), (5), (6), (7), (8).)

2 Sec. 4151.002. EXEMPTIONS. A person is not an
3 administrator if the person is:

4 (1) an employer acting on behalf of its employees or
5 the employees of one or more subsidiaries or affiliated
6 corporations of the employer;

7 (2) a union acting on behalf of its members;

8 (3) an insurer or a group hospital service corporation
9 subject to Chapter 842 acting with respect to a policy lawfully
10 issued and delivered by the insurer or corporation in and under the
11 law of a state in which the insurer or corporation was authorized to
12 engage in the business of insurance;

13 (4) a health maintenance organization that is
14 authorized to operate in this state under Chapter 843 with respect
15 to any activity that is specifically regulated under that chapter,
16 Chapter 1271, 1272, or 1367, or Subchapter A, Chapter 1452;

17 (5) an agent licensed under Subchapter B, Chapter
18 4054, who receives commissions as an agent and is acting:

19 (A) under appointment on behalf of an insurer
20 authorized to engage in the business of insurance in this state; and

21 (B) in the customary scope and duties of the
22 person's authority as an agent;

23 (6) a creditor acting on behalf of its debtor with
24 respect to insurance that covers a debt between the creditor and its
25 debtor, if the creditor performs only the functions of a group
26 policyholder or a creditor;

27 (7) a trust established in conformity with 29 U.S.C.

1 Section 186 or a trustee or employee who is acting under the trust;

2 (8) a trust that is exempt from taxation under Section
3 501(a), Internal Revenue Code of 1986, or a trustee or employee
4 acting under the trust;

5 (9) a custodian or a custodian's agent or employee who
6 is acting under a custodian account that complies with Section
7 401(f), Internal Revenue Code of 1986;

8 (10) a bank, credit union, savings and loan
9 association, or other financial institution that is subject to
10 supervision or examination under federal or state law by a federal
11 or state regulatory authority, if the institution is performing
12 only those functions for which the institution holds a license
13 under federal or state law;

14 (11) a company that advances and collects a premium or
15 charge from its credit card holders on their authorization, if the
16 company does not adjust or settle claims and acts only in the
17 company's debtor-creditor relationship with its credit card
18 holders;

19 (12) a person who adjusts or settles claims in the
20 normal course of the person's practice or employment as a licensed
21 attorney and who does not collect any premium or charge in
22 connection with annuities or with life, health, or accident
23 benefits, including pharmacy benefits;

24 (13) an adjuster licensed by the department who is
25 engaged in the performance of the person's powers and duties as an
26 adjuster in the scope of the person's license;

27 (14) a person who provides technical, advisory,

1 utilization review, precertification, or consulting services to an
2 insurer, plan, or plan sponsor but does not make any management or
3 discretionary decisions on behalf of the insurer, plan, or plan
4 sponsor;

5 (15) an attorney in fact for a Lloyd's plan operating
6 under Chapter 941 or for a reciprocal or interinsurance exchange
7 operating under Chapter 942 who is acting in the capacity of
8 attorney in fact under the applicable chapter;

9 (16) a joint fund, risk management pool, or
10 self-insurance pool composed of political subdivisions of this
11 state that participate in a fund or pool through interlocal
12 agreements, any nonprofit administrative agency or governing body
13 or other nonprofit entity that acts solely on behalf of a fund,
14 pool, agency, or body, or any other fund, pool, agency, or body
15 established under or for the purpose of implementing an interlocal
16 governmental agreement;

17 (17) a self-insured political subdivision;

18 (18) a plan under which insurance benefits are
19 provided exclusively by an insurer authorized to engage in the
20 business of insurance in this state and the administrator of which
21 is:

22 (A) a full-time employee of the plan's organizing
23 or sponsoring association, trust, or other entity; or

24 (B) a trustee of the organizing or sponsoring
25 trust; or

26 (19) a parent of a wholly owned direct or indirect
27 subsidiary insurer authorized to engage in the business of

1 insurance in this state or a wholly owned direct or indirect
2 subsidiary insurer that is a part of the parent's holding company
3 system that, under an agreement regulated and approved under
4 Chapter 823 or a similar statute of the domiciliary state if the
5 parent or subsidiary insurer is a foreign insurer engaged in
6 business in this state, on behalf of only itself or an affiliated
7 insurer:

8 (A) collects premiums or contributions, if the
9 parent or subsidiary insurer:

10 (i) prepares only billing statements and
11 places those statements in the United States mail; and

12 (ii) causes all collected premiums to be
13 deposited directly in a depository account of the particular
14 affiliated insurer; or

15 (B) furnishes proof-of-loss forms, reviews
16 claims, determines the amount of the liability for those claims,
17 and negotiates settlements, if the parent or subsidiary insurer
18 pays claims only from the funds of the particular subsidiary by
19 checks or drafts of that subsidiary. (V.T.I.C. Art. 21.07-6, Sec.
20 1(1) (part).)

21 Sec. 4151.003. APPLICABILITY OF OTHER PROVISIONS OF CODE.
22 An administrator is subject to Section 823.457, Subchapter H of
23 Chapter 101, Chapter 541, Subchapter A of Chapter 542, and Chapter
24 804. (V.T.I.C. Art. 21.07-6, Sec. 23.)

25 Sec. 4151.004. APPLICABILITY TO CERTAIN INSURERS AND HEALTH
26 MAINTENANCE ORGANIZATIONS. An insurer or health maintenance
27 organization that is not exempt under Section 4151.002(3) or (4) is

1 subject to all provisions of this chapter other than Sections
2 4151.005, 4151.051-4151.054, 4151.056, and 4151.206(a)(1).
3 (V.T.I.C. Art. 21.07-6, Sec. 24.)

4 Sec. 4151.005. ADMINISTRATOR NOT INSURANCE AGENT. (a) An
5 administrator licensed in any state who accepts an agent's
6 commission for coverage for a risk located in this state and
7 disburses that commission to an agent in this state is not
8 considered an agent for purposes of this state's laws relating to
9 the licensing of agents.

10 (b) The exemption provided by this section does not
11 authorize an administrator to perform any other act for which a
12 license as an agent is required by law. (V.T.I.C. Art. 21.07-6,
13 Sec. 10.)

14 Sec. 4151.006. RULES. The commissioner may adopt fair and
15 reasonable rules, minimum standards, or limitations as appropriate
16 to augment and implement this chapter. (V.T.I.C. Art. 21.07-6,
17 Sec. 2.)

18 [Sections 4151.007-4151.050 reserved for expansion]

19 SUBCHAPTER B. CERTIFICATE OF AUTHORITY

20 Sec. 4151.051. CERTIFICATE OF AUTHORITY REQUIRED. (a) An
21 individual, corporation, organization, trust, partnership, or
22 other legal entity may not act as or hold itself out as an
23 administrator unless the entity is covered by and is engaging in
24 business under a certificate of authority issued under this
25 chapter.

26 (b) An administrator is required to hold only one
27 certificate of authority issued under this chapter. (V.T.I.C. Art.

1 21.07-6, Secs. 3(a), (b).)

2 Sec. 4151.052. APPLICATION. An application for a
3 certificate of authority to engage in business as an administrator
4 must be in a form prescribed by the commissioner and must include
5 the following:

6 (1) a copy of each basic organizational document of
7 the applicant, including the articles of incorporation, bylaws,
8 articles of association, trade name certificate, and any other
9 similar document and a copy of any amendment to any of those
10 documents;

11 (2) a description of the applicant and the applicant's
12 services, facilities, and personnel;

13 (3) if the applicant is not domiciled in this state, a
14 power of attorney executed by the applicant appointing the
15 commissioner, the commissioner's successors in office, or the
16 commissioner's appointed designee as the applicant's attorney in
17 this state on whom process may be served in any legal action or
18 proceeding based on a cause of action arising in this state against
19 the applicant;

20 (4) an audited financial statement of the applicant
21 covering the preceding three calendar years or any lesser period
22 that the applicant and any predecessors of the applicant have been
23 in existence, or if an audited financial statement is not
24 available, an unaudited financial statement as of a date not
25 earlier than the 120th day before the date the application is filed,
26 accompanied by an affidavit or certification of the applicant that:

27 (A) the unaudited financial statement is true and

1 correct, as of its date; and

2 (B) a material change in financial condition has
3 not occurred from the date of the financial statement to the
4 execution date of the affidavit or certification; and

5 (5) any other information the commissioner reasonably
6 requires. (V.T.I.C. Art. 21.07-6, Sec. 4.)

7 Sec. 4151.053. APPROVAL OF APPLICATION. The commissioner
8 shall approve an application for a certificate of authority to
9 engage in business in this state as an administrator if the
10 commissioner is satisfied that:

11 (1) granting the application would not violate a
12 federal or state law;

13 (2) the financial condition of the applicant or of
14 each person who would operate or control the applicant is such that
15 granting a certificate of authority would not be adverse to the
16 public interest;

17 (3) the applicant has not attempted to obtain the
18 certificate of authority through fraud or bad faith;

19 (4) the applicant has complied with this chapter and
20 rules adopted by the commissioner under this chapter; and

21 (5) the name under which the applicant will engage in
22 business in this state is not so similar to that of another
23 administrator or insurer that it is likely to mislead the public.
24 (V.T.I.C. Art. 21.07-6, Sec. 5(a).)

25 Sec. 4151.054. DENIAL OF APPLICATION. (a) If the
26 commissioner is unable to approve an application for a certificate
27 of authority, the commissioner shall:

1 (1) provide the applicant with written notice
2 specifying each deficiency in the application; and

3 (2) offer the applicant the opportunity for a hearing
4 to address each reason and circumstance for possible denial of the
5 application.

6 (b) The commissioner must provide an opportunity for a
7 hearing before the commissioner finally denies an application.

8 (c) At the hearing, the applicant has the burden to produce
9 sufficient competent evidence on which the commissioner can make
10 the determinations required by Section 4151.053. (V.T.I.C. Art.
11 21.07-6, Sec. 5(b).)

12 Sec. 4151.055. FIDELITY BOND REQUIRED. (a) If the
13 commissioner approves an application for a certificate of
14 authority, before the commissioner issues the certificate of
15 authority, the applicant must:

16 (1) obtain and maintain a fidelity bond that complies
17 with this section; and

18 (2) submit to the commissioner proof that the
19 applicant has obtained the fidelity bond.

20 (b) The fidelity bond must protect against an act of fraud
21 or dishonesty by the applicant in exercising the applicant's powers
22 and duties as administrator.

23 (c) The fidelity bond may not be less than \$10,000 and may
24 not be more than the lesser of:

25 (1) 10 percent of the amount of funds handled during
26 the preceding year or, if no funds were handled during the preceding
27 year, 10 percent of the amount of funds reasonably estimated to be

1 handled by the administrator during the current calendar year; or

2 (2) \$500,000.

3 (d) On written request by an administrator for reduction of
4 the amount of the fidelity bond for a particular year, the
5 commissioner may authorize the reduction of the amount of the bond
6 if the administrator presents evidence that the amount of funds to
7 be handled during that year will be less than the amount handled
8 during the preceding year.

9 (e) For purposes of this section, the amount of funds
10 handled by a person in the person's capacity as administrator is
11 either the total amount of premiums and contributions received by
12 the administrator or the total amount of benefits paid by the
13 administrator, whichever is greater, during the preceding calendar
14 year in all jurisdictions in which the person acts as an
15 administrator.

16 (f) Unless the administrator and the insurer or plan agree
17 otherwise in writing, an administrator is required to obtain and
18 maintain only one fidelity bond for all insurers and plans for which
19 the administrator acts as administrator in this state. (V.T.I.C.
20 Art. 21.07-6, Sec. 6.)

21 Sec. 4151.056. DURATION OF CERTIFICATE OF AUTHORITY. A
22 certificate of authority issued to an administrator under this
23 chapter is effective until it is suspended, canceled, or revoked.
24 The issuance, denial, suspension, cancellation, or revocation of a
25 certificate of authority to act as an administrator is subject to:

26 (1) Subchapters B and C, Chapter 4005; and

27 (2) Chapter 82. (V.T.I.C. Art. 21.07-6, Sec. 3(c).)

[Sections 4151.057-4151.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF
THIRD-PARTY ADMINISTRATORS

Sec. 4151.101. WRITTEN AGREEMENT WITH INSURER OR PLAN SPONSOR REQUIRED. An administrator may provide services only under a written agreement with an insurer or plan sponsor. (V.T.I.C. Art. 21.07-6, Sec. 11(a).)

Sec. 4151.102. CONTENTS OF WRITTEN AGREEMENT. (a) The written agreement must include each requirement prescribed by this subchapter except for a requirement that does not apply to any function the administrator performs.

(b) If a policy or plan document is issued to a trustee, a copy of the trust agreement and any amendment to that trust agreement becomes part of the written agreement.

(c) The written agreement may not contain a provision that unreasonably restricts the availability to a plan participant of an individual life, health, or accident policy or annuity through an agent selected by the plan participant. (V.T.I.C. Art. 21.07-6, Secs. 11(d), (e), (f).)

Sec. 4151.103. RETENTION OF WRITTEN AGREEMENT; INSPECTION BY COMMISSIONER. (a) During the term of the written agreement, the administrator and the insurer, plan, or plan sponsor shall retain a copy of the agreement as part of their official records.

(b) On written request by the commissioner, the administrator shall make the written agreement available for inspection by the commissioner or the commissioner's designee.

(c) Information the commissioner or the commissioner's

1 designee obtains from the written agreement is confidential and may
2 not be made available to the public. An employee of the department
3 may examine the information in exercising powers and performing
4 duties under this chapter. (V.T.I.C. Art. 21.07-6, Secs. 11(b),
5 (c).)

6 Sec. 4151.104. NOTICE OF USE OF ADMINISTRATOR'S SERVICES.
7 If an insurer, plan, or plan sponsor uses the services of an
8 administrator, the administrator shall give written notice to each
9 insured or plan participant of the administrator's identity and the
10 relationship among the administrator and the insurer, plan, or plan
11 sponsor and the insured or plan participant. The insurer, plan, or
12 plan sponsor must approve the notice before the notice is
13 distributed. (V.T.I.C. Art. 21.07-6, Sec. 13(a).)

14 Sec. 4151.105. PAYMENTS TO ADMINISTRATOR. (a) If an
15 insurer, plan, or plan sponsor uses the services of an
16 administrator:

17 (1) a payment of a premium or contribution to the
18 administrator by or on behalf of an insured or plan participant is
19 considered to have been received by the insurer, plan, or plan
20 sponsor; and

21 (2) a payment of a return premium, contribution, or
22 claim to the administrator by the insurer, plan, or plan sponsor is
23 not considered payment to the insured, plan participant, or
24 claimant until the insured, plan participant, or claimant receives
25 the payment.

26 (b) This section does not limit a right of an insurer, plan,
27 or plan sponsor against the administrator resulting from the

1 administrator's failure to make a payment to an insured, plan
2 participant, or claimant. (V.T.I.C. Art. 21.07-6, Sec. 12.)

3 Sec. 4151.106. CERTAIN FUNDS COLLECTED OR RECEIVED BY
4 ADMINISTRATOR. (a) An administrator who collects funds must
5 identify and state separately in writing the amount of any premium
6 or contribution specified by the insurer, plan, or plan sponsor for
7 the coverage and provide the information to any person who pays to
8 the administrator a premium or contribution.

9 (b) An administrator holds in a fiduciary capacity:

10 (1) a premium or contribution the administrator
11 collects on behalf of an insurer, plan, or plan sponsor; and

12 (2) a return premium the administrator receives from
13 an insurer, plan, or plan sponsor. (V.T.I.C. Art. 21.07-6, Secs.
14 13(b), 17(a).)

15 Sec. 4151.107. DELIVERY OR DEPOSIT OF CERTAIN FUNDS
16 RECEIVED BY ADMINISTRATOR. (a) On receiving a premium,
17 contribution, or return premium, an administrator shall:

18 (1) timely deliver the funds to the person entitled to
19 the funds according to terms of the written agreement; or

20 (2) promptly deposit the funds in a fiduciary bank
21 account established and maintained by the administrator.

22 (b) If premiums or contributions deposited in a fiduciary
23 bank account were collected on behalf of more than one insurer,
24 plan, or plan sponsor, the administrator shall:

25 (1) maintain records that clearly record separately
26 the deposits to and withdrawals from the account on behalf of each
27 insurer, plan, or plan sponsor; and

1 (2) on request of an insurer, plan, or plan sponsor,
2 provide to the insurer, plan, or plan sponsor a copy of the records
3 relating to deposits and withdrawals on behalf of that insurer or
4 plan.

5 (c) The requirements of Subsection (b):

6 (1) are in addition to requirements of any other
7 federal or state law; and

8 (2) do not authorize the commingling of funds if
9 otherwise prohibited by law. (V.T.I.C. Art. 21.07-6, Secs. 17(b),
10 (c).)

11 Sec. 4151.108. WITHDRAWALS FROM FIDUCIARY ACCOUNT. A
12 withdrawal from a fiduciary bank account established under Section
13 4151.107 may be made only as provided in the written agreement for
14 any of the following purposes:

15 (1) delivery to an insurer, plan, or plan sponsor
16 entitled to payment;

17 (2) deposit in an account controlled and maintained in
18 the name of the insurer, plan, or plan sponsor;

19 (3) transfer to and deposit in a claims payment
20 account for payment of a claim as provided by Section 4151.111;

21 (4) payment to a group policyholder for delivery to
22 the insurer entitled to payment;

23 (5) payment to the administrator of the
24 administrator's commission, fees, or charges;

25 (6) delivery of a return premium to any person
26 entitled to payment; or

27 (7) payment of a premium for stop-loss or excess loss

1 insurance. (V.T.I.C. Art. 21.07-6, Sec. 17(e).)

2 Sec. 4151.109. PAYMENT OF CLAIMS FROM FIDUCIARY ACCOUNT
3 PROHIBITED. An administrator may not pay a claim from a fiduciary
4 bank account established under Section 4151.107. (V.T.I.C. Art.
5 21.07-6, Sec. 17(d).)

6 Sec. 4151.110. UNDERWRITING STANDARDS. If an administrator
7 has the authority to accept or reject a risk, the written agreement
8 must address underwriting or other standards of the insurer or
9 plan. (V.T.I.C. Art. 21.07-6, Sec. 16.)

10 Sec. 4151.111. ADJUDICATION OF CLAIMS. (a) An
11 administrator shall adjudicate a claim not later than the 60th day
12 after the date on which the administrator receives valid proof of
13 loss in connection with the claim.

14 (b) The administrator shall pay each claim on a draft
15 authorized by the insurer, plan, or plan sponsor in the written
16 agreement. (V.T.I.C. Art. 21.07-6, Sec. 18.)

17 Sec. 4151.112. MAINTENANCE OF BOOKS AND RECORDS. (a) An
18 administrator shall maintain at the administrator's principal
19 administrative office adequate books and records of each
20 transaction in which the administrator engages with an insurer,
21 plan, plan sponsor, insured, or plan participant.

22 (b) The administrator shall maintain the books and records:
23 (1) until the fifth anniversary of the end of the term
24 of the written agreement to which the books and records relate; and
25 (2) in accordance with prudent standards of insurance
26 recordkeeping. (V.T.I.C. Art. 21.07-6, Secs. 14(a), (b), (c).)

27 Sec. 4151.113. ACCESS TO BOOKS AND RECORDS. (a) For the

1 purpose of examination, audit, and inspection, the administrator
2 shall provide to the commissioner and the commissioner's designee
3 access to the books and records maintained as required by Section
4 4151.112.

5 (b) A trade secret, including the identity and address of a
6 policyholder or certificate holder, is confidential, except the
7 commissioner may use that information in a proceeding against the
8 administrator.

9 (c) An insurer, plan, or plan sponsor is entitled to
10 continuing access to the books and records sufficient to permit the
11 insurer, plan, or plan sponsor to fulfill a contractual obligation
12 to an insured or plan participant. The right provided by this
13 subsection is subject to any restriction included in the written
14 agreement relating to the parties' proprietary rights to the books
15 and records. (V.T.I.C. Art. 21.07-6, Secs. 14(d), (e), (f).)

16 Sec. 4151.114. DISPOSITION OF BOOKS AND RECORDS ON
17 TERMINATION OF WRITTEN AGREEMENT. On termination of the written
18 agreement, an administrator may fulfill the requirements of
19 Sections 4151.112 and 4151.113 by:

20 (1) delivering the books and records:

21 (A) to a successor administrator; or

22 (B) if there is not a successor administrator, to
23 the insurer, plan, or plan sponsor; and

24 (2) giving written notice to the commissioner of the
25 location of the books and records. (V.T.I.C. Art. 21.07-6, Sec.
26 14(g).)

27 Sec. 4151.115. CONFIDENTIALITY OF PERSONAL INFORMATION.

1 (a) Information that identifies an individual covered by a plan is
2 confidential.

3 (b) During the time information described by Subsection (a)
4 is in an administrator's custody or control, the administrator
5 shall take all reasonable precautions to prevent disclosure or use
6 of the information for a purpose unrelated to administration of the
7 plan.

8 (c) The administrator shall disclose information described
9 by Subsection (a) only:

10 (1) in response to a court order;

11 (2) for an examination conducted by the commissioner
12 under this chapter;

13 (3) for an audit or investigation conducted under the
14 Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et
15 seq.);

16 (4) to or at the request of the insurer or plan
17 sponsor; or

18 (5) with the written consent of the identified
19 individual or the individual's legal representative. (V.T.I.C.
20 Art. 21.07-6, Sec. 14A.)

21 Sec. 4151.116. ADVERTISING. Before an administrator uses
22 advertising relating to business underwritten by an insurer, plan,
23 or plan sponsor, the insurer, plan, or plan sponsor must approve use
24 of the advertising. (V.T.I.C. Art. 21.07-6, Sec. 15.)

25 Sec. 4151.117. COMPENSATION OF ADMINISTRATOR. An
26 administrator's compensation may be determined:

27 (1) as a percentage of the premiums or charges the

1 administrator collects or the amount of claims the administrator
2 pays or processes; or

3 (2) on another basis as specified in the written
4 agreement. (V.T.I.C. Art. 21.07-6, Sec. 19.)

5 [Sections 4151.118-4151.150 reserved for expansion]

6 SUBCHAPTER D. PHARMACY BENEFIT PLANS

7 Sec. 4151.151. DEFINITION. In this subchapter, "pharmacy
8 benefit manager" means a person, other than a pharmacy or
9 pharmacist, who acts as an administrator in connection with
10 pharmacy benefits. (V.T.I.C. Art. 21.07-6, Sec. 1(9).)

11 Sec. 4151.152. IDENTIFICATION CARDS. (a) Except as
12 provided by rules adopted by the commissioner, an administrator for
13 a plan that provides pharmacy benefits shall issue an
14 identification card to each individual covered by the plan. The
15 administrator shall issue the identification card not later than
16 the 30th day after the date the administrator receives notice that
17 the individual is eligible for the benefits.

18 (b) The commissioner by rule shall adopt standard
19 information to be included on the identification card. The
20 standard form identification card must include:

21 (1) the name or logo of the entity administering the
22 pharmacy benefits;

23 (2) the international identification number assigned
24 by the American National Standards Institute for the entity
25 administering the pharmacy benefits;

26 (3) the group number applicable to the covered
27 individual;

1 (4) the effective date of the coverage evidenced by
2 the card;

3 (5) a telephone number to be used to contact an
4 appropriate person to obtain information relating to the pharmacy
5 benefits provided under the coverage; and

6 (6) copayment information for generic and brand-name
7 prescription drugs. (V.T.I.C. Art. 21.07-6, Sec. 19A.)

8 Sec. 4151.153. DISCLOSURE OF CERTAIN PATIENT INFORMATION
9 PROHIBITED. (a) A pharmacy benefit manager may not sell a list of
10 patients that contains information through which the identity of an
11 individual patient is disclosed.

12 (b) A pharmacy benefit manager shall maintain all data that
13 identifies a patient in a confidential manner that prevents
14 disclosure to a third party unless the disclosure is otherwise
15 authorized by law or by the patient.

16 (c) This section does not prohibit:

17 (1) general advertising about a specific
18 pharmaceutical product or service; or

19 (2) the request and receipt by a person of information
20 regarding:

21 (A) a specific pharmaceutical product or
22 service;

23 (B) the person's own records or claims; or

24 (C) the person's dependent's records or claims.
25 (V.T.I.C. Art. 21.07-6, Sec. 19B.)

26 [Sections 4151.154-4151.200 reserved for expansion]

27 SUBCHAPTER E. REGULATION OF

THIRD-PARTY ADMINISTRATORS

Sec. 4151.201. EXAMINATION OF ADMINISTRATOR. (a) The commissioner may examine an administrator with regard to its business in this state.

(b) The commissioner may designate one or more employees to perform an examination. (V.T.I.C. Art. 21.07-6, Secs. 8(a), (b).)

Sec. 4151.202. CONTENTS OF EXAMINATION; ON-SITE EVALUATION. (a) An examination under Section 4151.201 must include a review of:

(1) each existing written agreement between the administrator and an insurer or plan sponsor; and

(2) the administrator's financial statements.

(b) The commissioner also may have examiners conduct an on-site evaluation of the administrator's personnel and facilities and any books and records of the administrator relating to the transaction of business by and the financial condition of the administrator.

(c) Before an examiner enters an administrator's property, the commissioner shall give notice to the administrator of the examiner's intent to conduct an on-site evaluation. The notice must:

(1) be in the form required by rule adopted by the commissioner; and

(2) include the date and estimated time that the examiner will enter the administrator's property.

(d) An examiner shall comply with operational rules of an administrator while on the administrator's property. (V.T.I.C.

1 Art. 21.07-6, Secs. 8(c), (d).)

2 Sec. 4151.203. COST OF EXAMINATION. The cost of an
3 examination under Section 4151.201 shall be paid from the fee
4 collected under Section 4151.206(a)(2) and with revenue from the
5 maintenance tax levied under Chapter 259. (V.T.I.C. Art. 21.07-6,
6 Sec. 8(f).)

7 Sec. 4151.204. EXAMINATION UNDER OATH. If necessary to
8 make a complete evaluation of the activities and operations of an
9 administrator, the commissioner may summon and examine under oath
10 the administrator and the administrator's personnel. (V.T.I.C.
11 Art. 21.07-6, Sec. 8(e).)

12 Sec. 4151.205. ANNUAL REPORT. (a) An administrator shall
13 annually, not later than March 1, file with the commissioner a
14 report on a form prescribed by the commissioner.

15 (b) The annual report must cover the preceding calendar
16 year. (V.T.I.C. Art. 21.07-6, Sec. 9.)

17 Sec. 4151.206. FEES. (a) The commissioner shall collect
18 and an applicant or administrator shall pay to the commissioner
19 fees in an amount to be determined by the commissioner as follows:

20 (1) a filing fee not to exceed \$1,000 for processing an
21 original application for a certificate of authority for an
22 administrator;

23 (2) a fee not to exceed \$500 for an examination under
24 Section 4201.201; and

25 (3) a filing fee not to exceed \$200 for an annual
26 report.

27 (b) The commissioner shall deposit a fee collected under

1 this section to the credit of the Texas Department of Insurance
2 operating account. (V.T.I.C. Art. 21.07-6, Sec. 20.)

3 Sec. 4151.207. ADMINISTRATIVE SANCTIONS. An administrator
4 or other person who violates this chapter is subject to the
5 sanctions provided by Chapter 82. (V.T.I.C. Art. 21.07-6, Sec.
6 22.)

7 Sec. 4151.208. OFFENSE. (a) An administrator commits an
8 offense if the administrator knowingly violates this chapter or a
9 rule of the commissioner adopted under this chapter.

10 (b) An offense under this section is a misdemeanor
11 punishable by a fine of not less than \$500 or more than \$5,000.
12 (V.T.I.C. Art. 21.07-6, Sec. 7.)

13 CHAPTER 4152. REINSURANCE INTERMEDIARIES

14 SUBCHAPTER A. GENERAL PROVISIONS

15 Sec. 4152.001. DEFINITIONS

16 Sec. 4152.002. CLASSIFICATION AS COMMERCIALY DOMICILED

17 INSURER

18 Sec. 4152.003. RIGHTS OF THIRD PARTIES NOT AFFECTED

19 Sec. 4152.004. RULES

20 [Sections 4152.005-4152.050 reserved for expansion]

21 SUBCHAPTER B. LICENSE REQUIREMENTS

22 Sec. 4152.051. LICENSE REQUIRED

23 Sec. 4152.052. QUALIFICATIONS

24 Sec. 4152.053. APPLICATION

25 Sec. 4152.054. SERVICE OF NOTICE, ORDERS, AND PROCESS

26 Sec. 4152.055. FEES

27 Sec. 4152.056. LICENSE ISSUANCE

1 Sec. 4152.057. PERSONS AUTHORIZED TO ACT UNDER LICENSE

2 Sec. 4152.058. BOND OR ERRORS AND OMISSIONS POLICY

3 Sec. 4152.059. LICENSE EXPIRATION AND RENEWAL

4 [Sections 4152.060-4152.100 reserved for expansion]

5 SUBCHAPTER C. EXAMINATION OF REINSURANCE INTERMEDIARIES

6 Sec. 4152.101. EXAMINATION BY COMMISSIONER

7 Sec. 4152.102. ACCESS TO AND MAINTENANCE OF BOOKS, BANK
8 ACCOUNTS, AND RECORDS

9 Sec. 4152.103. CONDUCT OF EXAMINATION

10 Sec. 4152.104. EXAMINATION EXPENSE

11 [Sections 4152.105-4152.150 reserved for expansion]

12 SUBCHAPTER D. REQUIREMENTS RELATING TO BROKERS

13 Sec. 4152.151. CONTRACT BETWEEN BROKER AND INSURER

14 Sec. 4152.152. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED
15 REINSURER

16 Sec. 4152.153. TRANSACTION RECORDS

17 Sec. 4152.154. EMPLOYMENT OF PERSON BY INSURER AND BROKER

18 [Sections 4152.155-4152.200 reserved for expansion]

19 SUBCHAPTER E. REQUIREMENTS RELATING TO MANAGERS

20 Sec. 4152.201. CONTRACT BETWEEN MANAGER AND INSURER

21 Sec. 4152.202. TERMINATION OF CONTRACT

22 Sec. 4152.203. ACCOUNTING FOR TRANSACTIONS

23 Sec. 4152.204. MANAGEMENT OF MONEY

24 Sec. 4152.205. TRANSACTION RECORDS

25 Sec. 4152.206. CONTRACT ASSIGNMENT PROHIBITED

26 Sec. 4152.207. COMPLIANCE WITH UNDERWRITING AND RATING

27 STANDARDS OF INSURER

1 Sec. 4152.208. SETTLEMENT OF CLAIMS

2 Sec. 4152.209. PAYMENT OF INTERIM PROFITS

3 Sec. 4152.210. AUDITED STATEMENT OF MANAGER'S FINANCIAL
4 CONDITION

5 Sec. 4152.211. DISCLOSURE OF RELATIONSHIPS WITH OTHER
6 INSURERS

7 Sec. 4152.212. ACTS OF MANAGER CONSIDERED ACTS OF
8 INSURER

9 Sec. 4152.213. ACTUARY'S OPINION ON ADEQUACY OF LOSS
10 RESERVES

11 Sec. 4152.214. PLACEMENT OF REINSURANCE WITH
12 UNAUTHORIZED REINSURER

13 Sec. 4152.215. PROHIBITIONS

14 Sec. 4152.216. EMPLOYMENT OF PERSON BY INSURER AND MANAGER
15 [Sections 4152.217-4152.250 reserved for expansion]

16 SUBCHAPTER F. REQUIREMENTS RELATING TO INSURERS

17 Sec. 4152.251. ENGAGEMENT OF SERVICES OF UNLICENSED BROKER
18 OR MANAGER

19 Sec. 4152.252. AUDITED STATEMENT OF MANAGER'S FINANCIAL
20 CONDITION

21 Sec. 4152.253. REVIEW OF UNDERWRITING AND CLAIMS PROCESSING
22 OPERATIONS

23 Sec. 4152.254. AUTHORITY FOR RETROCESSIONAL CONTRACTS OR
24 PARTICIPATION IN REINSURANCE SYNDICATES

25 Sec. 4152.255. NOTIFICATION OF TERMINATION OF MANAGER'S
26 CONTRACT

27 Sec. 4152.256. APPOINTMENT OF CERTAIN PERSONS TO BOARD OF

DIRECTORS PROHIBITED

[Sections 4152.257-4152.300 reserved for expansion]

SUBCHAPTER G. DISCIPLINE AND ENFORCEMENT

Sec. 4152.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
ACTION

Sec. 4152.302. IMPOSITION OF SANCTIONS

CHAPTER 4152. REINSURANCE INTERMEDIARIES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4152.001. DEFINITIONS. In this chapter:

(1) "Actuary" means a member in good standing of the
American Academy of Actuaries.

(2) "Broker" means a person, other than an officer or
employee of an insurer, who solicits, negotiates, or places
reinsurance business on behalf of an insurer and who may not
exercise the authority to bind reinsurance on behalf of that
insurer.

(3) "Control" has the meaning described by Sections
823.005 and 823.151.

(4) "Insurer" means a commercially domiciled insurer
or other person legally organized in this state to engage in the
business of insurance as an insurance company, including:

- (A) a capital stock insurance company;
- (B) a mutual insurance company;
- (C) a title insurance company;
- (D) a fraternal benefit society;
- (E) a local mutual aid association;
- (F) a statewide mutual assessment company;

- (G) a county mutual insurance company;
- (H) a Lloyd's plan;
- (I) a reciprocal or interinsurance exchange;
- (J) a stipulated premium company;
- (K) a group hospital service corporation;
- (L) a farm mutual insurance company; and
- (M) a risk retention group.

(5) "Manager" means a person who has the authority to bind reinsurance or who manages all or part of the reinsurance business of an insurer, including the management of a separate division, department, or underwriting office, and who acts as an agent for that insurer. The term does not include:

- (A) an employee of the insurer;
- (B) a manager of the United States branch of an alien insurer;
- (C) an underwriting manager who, under a contract, manages all of the reinsurance operations of an insurer, who is under common control with the insurer under Chapter 823, and whose compensation is not based on the volume of premiums written; or
- (D) a manager of a group, association, pool, or other organization of insurers who engages in joint underwriting or joint reinsurance and who is subject to examination by the insurance commissioner or other appropriate officer of the state in which the manager's principal business office is located.

(6) "Person" means an individual or a corporation, partnership, association, or other private legal entity.

1 (7) "Qualified United States financial institution"
2 means an institution that is:

3 (A) organized or, in the case of a United States
4 office of a foreign banking organization, licensed under the laws
5 of the United States or a state; and

6 (B) regulated, supervised, and examined by
7 United States federal or state authorities who have regulatory
8 authority over banks and trust companies.

9 (8) "Reinsurance" means a written contract that for
10 consideration transfers an insurance risk of loss between insurers
11 and indemnifies a ceding insurer against all or part of the loss
12 that the ceding insurer may sustain under an insurance policy the
13 ceding insurer has issued or assumed. The term does not include a
14 contract for the bulk sale, transfer, and assumption of direct
15 insurance policy liability to the insureds.

16 (9) "Reinsurance intermediary" means a broker or
17 manager.

18 (10) "Reinsurer" means an insurer who has the
19 authority to assume reinsurance, including retrocessions. The term
20 includes a retrocessionaire. (V.T.I.C. Art. 21.07-7, Secs. 2(1),
21 (2), (4), (5), (6), (7), (8), (9), (10), (11).)

22 Sec. 4152.002. CLASSIFICATION AS COMMERCIALY DOMICILED
23 INSURER. (a) For purposes of this chapter, a foreign or alien
24 insurer authorized to engage in the business of insurance in this
25 state is a commercially domiciled insurer if during the period
26 described by Subsection (b) the average of the gross premiums
27 written by the insurer in this state is:

1 (1) more than the average of the gross premiums
2 written by the insurer in the insurer's state of domicile; and

3 (2) 20 percent or more of the total gross premiums
4 written by the insurer in the United States, as reported in the
5 insurer's three most recent annual statements.

6 (b) The period applicable to Subsection (a) is:

7 (1) the three most recent fiscal years of the insurer
8 that precede the fiscal year in which the determination under this
9 section is made; or

10 (2) if the insurer has been authorized to engage in the
11 business of insurance in this state for less than the period
12 described by Subdivision (1), the period for which the insurer has
13 been authorized to engage in the business of insurance in this
14 state. (V.T.I.C. Art. 21.07-7, Sec. 2(3).)

15 Sec. 4152.003. RIGHTS OF THIRD PARTIES NOT AFFECTED. This
16 chapter does not restrict the rights of or confer any additional
17 rights on a policyholder, claimant, creditor, or other third party.
18 (V.T.I.C. Art. 21.07-7, Sec. 10(d).)

19 Sec. 4152.004. RULES. The commissioner may adopt
20 reasonable rules as necessary to implement this chapter. (V.T.I.C.
21 Art. 21.07-7, Sec. 11.)

22 [Sections 4152.005-4152.050 reserved for expansion]

23 SUBCHAPTER B. LICENSE REQUIREMENTS

24 Sec. 4152.051. LICENSE REQUIRED. (a) A person may not act
25 as a broker or manager in this state for an insurer engaged in the
26 business of insurance or reinsurance in this state unless the
27 person holds an appropriate license under this chapter.

1 (b) A person who holds a manager license is not required to
2 obtain a broker license but must comply with Subchapter D to act as
3 a broker. (V.T.I.C. Art. 21.07-7, Secs. 3(a), (h); Sec. 7(a).)

4 Sec. 4152.052. QUALIFICATIONS. The commissioner may
5 establish qualifications for a reinsurance intermediary license as
6 reasonably necessary to fulfill the requirements of this chapter.
7 (V.T.I.C. Art. 21.07-7, Sec. 3(f).)

8 Sec. 4152.053. APPLICATION. (a) An application for a
9 reinsurance intermediary license may not be accepted unless the
10 application shows on its face that the applicant has been engaged in
11 the business of insurance or reinsurance for at least three years.

12 (b) Each person authorized under Section 4152.057 to act as
13 a reinsurance intermediary under a reinsurance intermediary
14 license issued to an entity must be named in the application and any
15 supplement to the application. (V.T.I.C. Art. 21.07-7, Secs. 3(c)
16 (part), (g).)

17 Sec. 4152.054. SERVICE OF NOTICE, ORDERS, AND PROCESS. (a)
18 An applicant for a reinsurance intermediary license who is not a
19 resident of this state must:

20 (1) designate the commissioner as agent for service of
21 process in the manner, and with the same legal effect, as provided
22 by Chapter 804 for service of process on unauthorized insurers; and

23 (2) provide the commissioner with the name and address
24 of a resident of this state on whom a notice or order of the
25 commissioner or process affecting the applicant may be served.

26 (b) A license holder who is a nonresident shall notify the
27 commissioner in writing of each change in the license holder's

1 designated agent under Subsection (a)(2) not later than the 30th
2 day after the date on which the license holder makes the change. The
3 change does not take effect until acknowledged by the commissioner.
4 (V.T.I.C. Art. 21.07-7, Sec. 3(d).)

5 Sec. 4152.055. FEES. (a) The department shall collect a
6 nonrefundable licensing fee from each reinsurance intermediary who
7 applies for an original or renewal license in this state.

8 (b) The commissioner shall set the fees for original,
9 renewal, and reciprocal licenses in amounts that are reasonable and
10 necessary to cover the costs of the licensing program.

11 (c) The fees shall be deposited to the credit of the Texas
12 Department of Insurance operating account. Money deposited in the
13 account under this subsection may be used by the department only to
14 enforce this chapter. (V.T.I.C. Art. 21.07-7, Secs. 4(a), (b).)

15 Sec. 4152.056. LICENSE ISSUANCE. The commissioner shall
16 issue a reinsurance intermediary license to a person who complies
17 with this chapter. (V.T.I.C. Art. 21.07-7, Sec. 3(c) (part).)

18 Sec. 4152.057. PERSONS AUTHORIZED TO ACT UNDER LICENSE.
19 (a) A reinsurance intermediary license issued to a firm or
20 association authorizes each member of the firm or association and
21 any designated employee to act as a reinsurance intermediary under
22 the license.

23 (b) A reinsurance intermediary license issued to a
24 corporation authorizes each officer and any designated employee or
25 director of the corporation to act as a reinsurance intermediary
26 under the license. (V.T.I.C. Art. 21.07-7, Sec. 3(c) (part).)

27 Sec. 4152.058. BOND OR ERRORS AND OMISSIONS POLICY. (a)

1 The commissioner may require a reinsurance intermediary to:

2 (1) file a bond with the commissioner for the
3 protection of all insurers represented; or

4 (2) maintain an errors and omissions policy.

5 (b) The issuer of the bond or the errors and omissions
6 policy must be acceptable to the commissioner. The bond or the
7 policy must be in an amount determined by the commissioner to be
8 customary and adequate under the circumstances. (V.T.I.C. Art.
9 21.07-7, Sec. 3(b).)

10 Sec. 4152.059. LICENSE EXPIRATION AND RENEWAL. (a) A
11 reinsurance intermediary license is valid for two years from the
12 date of issuance and may be renewed for two-year terms.

13 (b) The commissioner may adopt standards for the renewal of
14 a reinsurance intermediary license. (V.T.I.C. Art. 21.07-7, Sec.
15 3(i).)

16 [Sections 4152.060-4152.100 reserved for expansion]

17 SUBCHAPTER C. EXAMINATION OF REINSURANCE INTERMEDIARIES

18 Sec. 4152.101. EXAMINATION BY COMMISSIONER. (a) A
19 reinsurance intermediary is subject to examination by the
20 commissioner of the reinsurance intermediary's:

21 (1) financial condition; and
22 (2) compliance with the laws of this state affecting
23 the conduct of the reinsurance intermediary's business.

24 (b) A manager may be examined as if the manager were an
25 insurer. (V.T.I.C. Art. 21.07-7, Secs. 9(a) (part), (b), (c)
26 (part).)

27 Sec. 4152.102. ACCESS TO AND MAINTENANCE OF BOOKS, BANK

1 ACCOUNTS, AND RECORDS. (a) The commissioner is entitled to access
2 to all books, bank accounts, and records of a reinsurance
3 intermediary.

4 (b) A reinsurance intermediary shall maintain books, bank
5 accounts, and records in a form usable by the commissioner.
6 (V.T.I.C. Art. 21.07-7, Sec. 9(a) (part).)

7 Sec. 4152.103. CONDUCT OF EXAMINATION. The commissioner,
8 one or more commissioned examiners, a certified public accountant,
9 or another person qualified to perform the examination shall
10 conduct an examination under this subchapter as the commissioner
11 considers necessary. (V.T.I.C. Art. 21.07-7, Sec. 9(c) (part).)

12 Sec. 4152.104. EXAMINATION EXPENSE. (a) A reinsurance
13 intermediary who is examined under this subchapter shall pay an
14 amount for the expense of the examination that the commissioner
15 certifies as just and reasonable.

16 (b) Expenses relating to an examination conducted under
17 this subchapter may be charged to the person examined in accordance
18 with Article 1.16. (V.T.I.C. Art. 21.07-7, Secs. 4(c), 9(c)
19 (part).)

20 [Sections 4152.105-4152.150 reserved for expansion]

21 SUBCHAPTER D. REQUIREMENTS RELATING TO BROKERS

22 Sec. 4152.151. CONTRACT BETWEEN BROKER AND INSURER. (a) A
23 broker and an insurer represented by the broker may enter into a
24 transaction only under a written contract that:

25 (1) is executed by a responsible officer of both the
26 broker and the insurer; and

27 (2) specifies the responsibilities of each party.

1 (b) At a minimum, a contract entered into under this section
2 must:

3 (1) authorize the insurer to terminate the broker's
4 authority in writing at any time;

5 (2) require the broker to:

6 (A) provide accounts to the insurer at least
7 quarterly that accurately detail all material transactions,
8 including information necessary to support all commissions,
9 charges, and other fees received by or owing to the broker;

10 (B) pay all money due the insurer not later than
11 the 30th day after the date of receipt;

12 (C) hold all money collected for the insurer's
13 account in a fiduciary capacity in a bank that is a qualified United
14 States financial institution; and

15 (D) if premiums or contributions are collected on
16 behalf of or for more than one insurer:

17 (i) maintain records to identify the
18 ownership interest of each insurer in money held in a fiduciary
19 capacity; and

20 (ii) provide to each insurer on request a
21 copy of the records relating to deposits and withdrawals on behalf
22 of or for that insurer;

23 (3) state that the broker will:

24 (A) comply with:

25 (i) Section 4152.153; and

26 (ii) the written standards established by
27 the insurer for the cession or retrocession of risks ceded;

(B) disclose to the insurer any relationship with a reinsurer to which business will be ceded or retroceded; and

(C) provide annually to each insurer with whom the broker transacts business an audited statement of the broker's financial condition prepared by a certified public accountant;

(4) identify:

(A) the name and address of the insurer;

(B) the kinds of insurance to be reinsured or retroceded;

(C) the type of reinsurance or retrocessions; and

(D) the limits of coverage; and

(5) state the effective date and expiration date of the contract. (V.T.I.C. Art. 21.07-7, Sec. 5(a) (part).)

Sec. 4152.152. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED REINSURER. Unless the ceding insurer releases the broker in writing from the broker's obligations under this section, a broker who places reinsurance on behalf of an authorized ceding insurer with a reinsurer that is not authorized, accredited, or trustee in this state under Article 3.10 or 5.75-1 shall:

(1) exercise due diligence in inquiring into the financial condition of the reinsurer;

(2) disclose to the ceding insurer the broker's findings in connection with the inquiry under Subdivision (1); and

(3) make available to the ceding insurer a copy of the current financial statement of the reinsurer. (V.T.I.C. Art. 21.07-7, Sec. 5(b).)

Sec. 4152.153. TRANSACTION RECORDS. (a) For at least 10

1 years after the expiration of each contract of reinsurance
2 transacted by a broker, the broker shall maintain a complete record
3 for each transaction that contains:

4 (1) the type of contract, limits, underwriting
5 restrictions, classes of risks, and territory;

6 (2) the period of coverage, including effective and
7 expiration dates, cancellation provisions, and notice requirements
8 regarding cancellation;

9 (3) reporting and settlement requirements regarding
10 balances;

11 (4) the rate used to compute the reinsurance premium;

12 (5) the name and address of each ceding or assuming
13 insurer;

14 (6) the rates of all reinsurance commissions,
15 including the commissions on any retrocessions handled by the
16 broker;

17 (7) related correspondence and memoranda;

18 (8) proof of placement;

19 (9) details regarding retrocessions handled by the
20 broker, including the identity and address of each retrocessionaire
21 and the respective percentage of each contract assumed or ceded;

22 (10) financial records, including premium and loss
23 accounts; and

24 (11) if the broker procures a reinsurance contract on
25 behalf of an authorized ceding insurer:

26 (A) written evidence that the assuming insurer
27 has agreed to assume the risk if the contract is procured directly

1 from an assuming insurer; or

2 (B) written evidence that the reinsurer has
3 delegated binding authority to the representative who has agreed to
4 assume the risk and that the representative is qualified to act as a
5 manager under this chapter if the contract is procured through a
6 representative of the assuming insurer, other than an employee.

7 (b) Each insurer subject to a contract of reinsurance
8 transacted by a broker is entitled to access to the information
9 maintained by the broker under Subsection (a) and may copy and audit
10 all accounts and records maintained by the broker related to the
11 insurer's business. The broker shall maintain the information in a
12 form usable by the insurer. (V.T.I.C. Art. 21.07-7, Secs. 5(c),
13 (d).)

14 Sec. 4152.154. EMPLOYMENT OF PERSON BY INSURER AND BROKER.
15 A person may not be employed by an insurer and a broker with whom the
16 insurer transacts business unless the broker is:

- 17 (1) under common control with the insurer; and
18 (2) subject to Chapter 823. (V.T.I.C. Art. 21.07-7,
19 Sec. 5(e).)

20 [Sections 4152.155-4152.200 reserved for expansion]

21 SUBCHAPTER E. REQUIREMENTS RELATING TO MANAGERS

22 Sec. 4152.201. CONTRACT BETWEEN MANAGER AND INSURER. (a) A
23 manager and an insurer represented by the manager may enter into a
24 transaction only under a written contract that:

- 25 (1) is executed by a responsible officer of both the
26 manager and the insurer;
27 (2) is approved by the insurer's board of directors or

1 attorney in fact;

2 (3) specifies the responsibilities of each party;

3 (4) identifies the rate, terms, and purpose of each
4 commission, charge, or other fee the manager may assess the
5 insurer; and

6 (5) at a minimum, incorporates the requirements of
7 Sections 4152.202-4152.214.

8 (b) Not later than the 30th day before the date the insurer
9 assumes or cedes business through the manager, a copy of the
10 executed contract must be filed with the commissioner for approval.
11 (V.T.I.C. Art. 21.07-7, Secs. 6(a), (j).)

12 Sec. 4152.202. TERMINATION OF CONTRACT. An insurer may:

13 (1) terminate a contract entered into under Section
14 4152.201 for cause on written notice to the manager by certified
15 mail, return receipt requested; and

16 (2) suspend the authority of the manager to assume or
17 cede business during any dispute regarding the cause for
18 termination. (V.T.I.C. Art. 21.07-7, Sec. 6(b).)

19 Sec. 4152.203. ACCOUNTING FOR TRANSACTIONS. A manager who
20 enters into a contract with an insurer under Section 4152.201 shall
21 provide accounts to the insurer at least quarterly that accurately
22 detail all material transactions, including information necessary
23 to support all commissions, charges, and other fees received by or
24 owing to the manager. (V.T.I.C. Art. 21.07-7, Sec. 6(c) (part).)

25 Sec. 4152.204. MANAGEMENT OF MONEY. (a) A manager shall
26 pay an insurer at least monthly all money due the insurer under a
27 contract entered into under Section 4152.201.

1 (b) The manager must hold all money collected for the
2 insurer's account in a fiduciary capacity in a bank that is a
3 qualified United States financial institution. The manager may not
4 retain more than three months of estimated claims payments and
5 allocated loss adjustment expenses.

6 (c) If premiums or contributions are collected on behalf of
7 or for more than one insurer, the manager shall:

8 (1) keep a separate account for each insurer;

9 (2) maintain a copy of the records for each account;
10 and

11 (3) provide to each insurer on request a copy of the
12 records relating to deposits and withdrawals on behalf of or for
13 that insurer. (V.T.I.C. Art. 21.07-7, Secs. 6(c) (part), (d),
14 (e).)

15 Sec. 4152.205. TRANSACTION RECORDS. (a) For at least 10
16 years after the expiration of each reinsurance contract transacted
17 by a manager, the manager shall maintain a complete record for each
18 transaction that contains:

19 (1) the type of contract, limits, underwriting
20 restrictions, classes of risks, and territory;

21 (2) the period of coverage, including effective and
22 expiration dates, cancellation provisions and notice requirements
23 regarding cancellation, and disposition of outstanding reserves on
24 covered risks;

25 (3) reporting and settlement requirements regarding
26 balances;

27 (4) the rate used to compute the reinsurance premium;

1 (5) the name and address of each ceding or assuming
2 insurer;

3 (6) the rates of all reinsurance commissions,
4 including the commissions on any retrocessions handled by the
5 manager;

6 (7) related correspondence and memoranda;

7 (8) proof of placement;

8 (9) details regarding retrocessions handled by the
9 manager, as permitted by Section 4152.254, including the identity
10 and address of each retrocessionaire and the respective percentage
11 of each contract assumed;

12 (10) financial records, including premium and loss
13 accounts; and

14 (11) if the manager procures a reinsurance contract on
15 behalf of a ceding insurer:

16 (A) written evidence that the assuming insurer
17 has agreed to assume the risk if the contract is procured directly
18 from an assuming insurer; or

19 (B) written evidence that the reinsurer has
20 delegated binding authority to the representative who has agreed to
21 assume the risk and that the representative is qualified to act as a
22 manager under this chapter if the contract is procured through a
23 representative of the assuming insurer, other than an employee.

24 (b) Each insurer is entitled to access to the information
25 maintained by the manager and may copy all accounts and records
26 maintained by the manager related to the insurer's business. The
27 manager shall maintain the information in a form usable by the

insurer. (V.T.I.C. Art. 21.07-7, Secs. 6(f), (g).)

Sec. 4152.206. CONTRACT ASSIGNMENT PROHIBITED. A manager may not assign in whole or in part a contract entered into under Section 4152.201. (V.T.I.C. Art. 21.07-7, Sec. 6(h).)

Sec. 4152.207. COMPLIANCE WITH UNDERWRITING AND RATING STANDARDS OF INSURER. A manager shall comply with the written underwriting and rating standards established by an insurer with whom the manager has entered into a contract under Section 4152.201 for the acceptance, rejection, or cession of all risks. (V.T.I.C. Art. 21.07-7, Sec. 6(i).)

Sec. 4152.208. SETTLEMENT OF CLAIMS. (a) This section applies only to a contract entered into under Section 4152.201 that permits a manager to settle claims on behalf of an insurer.

(b) All claims must be reported to the insurer at least quarterly.

(c) The manager shall send a copy of the claim file to the insurer at the insurer's request or as soon as it is known that the claim:

(1) has the potential to exceed the lesser of:

(A) an amount determined by the commissioner; or

(B) the limit set by the insurer;

(2) involves a coverage dispute;

(3) may exceed the manager's claims settlement authority;

(4) has been open for more than six months; or

(5) has been closed by payment of the lesser of:

(A) an amount determined by the commissioner; or

1 (B) the limit set by the insurer.

2 (d) A claim file is the joint property of the insurer and
3 manager, except that on an order of liquidation of the insurer the
4 file becomes the sole property of the insurer or the insurer's
5 estate. The manager is entitled to reasonable access to the claim
6 file and may copy the file on a timely basis.

7 (e) Any settlement authority granted to the manager may be
8 terminated for cause on the insurer's written notice by certified
9 mail, return receipt requested, to the manager or on the
10 termination of the contract. The insurer may suspend the
11 settlement authority during any dispute regarding the cause of
12 termination. (V.T.I.C. Art. 21.07-7, Sec. 6(k).)

13 Sec. 4152.209. PAYMENT OF INTERIM PROFITS. If a contract
14 entered into under Section 4152.201 provides for the sharing of
15 interim profits by the manager, interim profits may not be paid
16 until:

17 (1) the first anniversary of the end of each
18 underwriting period for property business, the fifth anniversary of
19 the end of each underwriting period for casualty business, or the
20 expiration of the period set by the executive director for those or
21 other specified kinds of insurance; and

22 (2) the adequacy of reserves on remaining claims has
23 been verified under Section 4152.213. (V.T.I.C. Art. 21.07-7, Sec.
24 6(1).)

25 Sec. 4152.210. AUDITED STATEMENT OF MANAGER'S FINANCIAL
26 CONDITION. (a) A manager shall provide annually to each insurer
27 and reinsurer with whom the manager transacts business an audited

1 statement of the manager's financial condition.

2 (b) The statement must be prepared by an independent
3 certified public accountant in a form acceptable to the
4 commissioner. (V.T.I.C. Art. 21.07-7, Secs. 6(m), 8(b) (part).)

5 Sec. 4152.211. DISCLOSURE OF RELATIONSHIPS WITH OTHER
6 INSURERS. Before ceding or assuming any business on behalf of an
7 insurer under a contract entered into under Section 4152.201, a
8 manager shall disclose to the insurer any relationship the manager
9 has with another insurer. (V.T.I.C. Art. 21.07-7, Sec. 6(o).)

10 Sec. 4152.212. ACTS OF MANAGER CONSIDERED ACTS OF INSURER.
11 The acts of a manager are considered to be the acts of the insurer on
12 whose behalf the manager is acting. (V.T.I.C. Art. 21.07-7, Sec.
13 6(p).)

14 Sec. 4152.213. ACTUARY'S OPINION ON ADEQUACY OF LOSS
15 RESERVES. In addition to any other required loss reserve
16 certification, a manager who establishes loss reserves shall
17 provide annually, or more frequently as required by other law, an
18 opinion from an actuary attesting to the adequacy of the loss
19 reserves established for losses incurred and outstanding on
20 business produced by the manager. (V.T.I.C. Art. 21.07-7, Sec.
21 6(q).)

22 Sec. 4152.214. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED
23 REINSURER. (a) Unless the ceding insurer releases the manager in
24 writing from the manager's obligations under this section, a
25 manager who places reinsurance on behalf of an authorized ceding
26 insurer with a reinsurer that is not authorized, accredited, or
27 trustee in this state under Article 3.10 or 5.75-1 shall:

1 (1) exercise due diligence in inquiring into the
2 financial condition of the reinsurer;

3 (2) disclose to the ceding insurer the manager's
4 findings in connection with the inquiry under Subdivision (1); and

5 (3) make available to the ceding insurer a copy of the
6 current financial statement of the reinsurer.

7 (b) A ceding insurer that releases a manager from the
8 manager's obligations under Subsection (a) assumes those
9 obligations. (V.T.I.C. Art. 21.07-7, Sec. 6(r).)

10 Sec. 4152.215. PROHIBITIONS. (a) A reinsurance
11 intermediary acting as a manager may not:

12 (1) bind retrocessions on behalf of an insurer, except
13 that the manager may bind facultative retrocessions under
14 obligatory retrocessional agreements if the contract entered into
15 with the insurer under Section 4152.201 contains reinsurance
16 underwriting guidelines for those retrocessions that include:

17 (A) a list of reinsurers with whom those
18 automatic agreements are in effect; and

19 (B) for each reinsurer:

20 (i) the coverages and amounts or
21 percentages that may be reinsured; and

22 (ii) commission schedules;

23 (2) commit an insurer to participate in a reinsurance
24 syndicate;

25 (3) appoint or contract with a broker without ensuring
26 that the broker is qualified to act as a manager under this chapter;

27 (4) without prior approval of the insurer, pay or

1 commit an insurer to pay a claim that exceeds the lesser of:

2 (A) an amount specified by the insurer; or

3 (B) one percent of the insurer's policyholders'
4 surplus as of December 31 of the last complete calendar year; or

5 (5) collect a payment from a retrocessionaire or
6 commit an insurer to a claim settlement with a retrocessionaire
7 without prior approval of the insurer.

8 (b) If prior approval is given as provided by Subsection
9 (a)(5), a report must be forwarded to the reinsurer as provided by
10 Section 4152.203. (V.T.I.C. Art. 21.07-7, Sec. 7(b).)

11 Sec. 4152.216. EMPLOYMENT OF PERSON BY INSURER AND MANAGER.
12 A person may not be employed by an insurer and a manager with whom
13 the insurer transacts business unless the manager is:

14 (1) under common control with the insurer; and

15 (2) subject to Chapter 823. (V.T.I.C. Art. 21.07-7,
16 Sec. 7(c).)

17 [Sections 4152.217-4152.250 reserved for expansion]

18 SUBCHAPTER F. REQUIREMENTS RELATING TO INSURERS

19 Sec. 4152.251. ENGAGEMENT OF SERVICES OF UNLICENSED BROKER
20 OR MANAGER. (a) Except as provided by Subsection (b), an insurer
21 may not engage the services of a person to act as a broker or manager
22 on the insurer's behalf unless the person holds a license if
23 required by Section 4152.051.

24 (b) An insurer, or an employee, attorney, or actuary of an
25 insurer, may negotiate and obtain reinsurance for that insurer
26 without holding a broker or manager license or without using the
27 services of a broker or manager if that insurer, employee,

1 attorney, or actuary does not otherwise hold the person out as a
2 broker or manager or perform the duties or provide the services of a
3 broker or manager. (V.T.I.C. Art. 21.07-7, Sec. 8(a).)

4 Sec. 4152.252. AUDITED STATEMENT OF MANAGER'S FINANCIAL
5 CONDITION. An insurer shall obtain annually an audited statement
6 as provided by Section 4152.210 of the financial condition of each
7 manager with whom the insurer transacts business. (V.T.I.C. Art.
8 21.07-7, Sec. 8(b) (part).)

9 Sec. 4152.253. REVIEW OF UNDERWRITING AND CLAIMS PROCESSING
10 OPERATIONS. An insurer shall conduct at least semiannually an
11 on-site review of the underwriting and claims processing operations
12 of a manager with whom the insurer enters into a contract under
13 Section 4152.201. (V.T.I.C. Art. 21.07-7, Sec. 6(n).)

14 Sec. 4152.254. AUTHORITY FOR RETROCESSIONAL CONTRACTS OR
15 PARTICIPATION IN REINSURANCE SYNDICATES. Binding authority for all
16 retrocessional contracts or participation in reinsurance
17 syndicates rests with an officer of the insurer. That officer may
18 not be affiliated with a manager acting for the insurer. (V.T.I.C.
19 Art. 21.07-7, Sec. 8(c).)

20 Sec. 4152.255. NOTIFICATION OF TERMINATION OF MANAGER'S
21 CONTRACT. (a) Not later than the 30th day after the date an insurer
22 terminates a manager's contract, the insurer shall provide written
23 notice to the commissioner of the termination, including the
24 reasons for termination.

25 (b) The notice is a privileged communication and is not
26 subject to public disclosure or admission into evidence in any
27 proceeding. (V.T.I.C. Art. 21.07-7, Sec. 8(d).)

1 Sec. 4152.256. APPOINTMENT OF CERTAIN PERSONS TO BOARD OF
2 DIRECTORS PROHIBITED. (a) This section does not apply to a
3 relationship governed by Chapter 823.

4 (b) An insurer may not appoint to the insurer's board of
5 directors an officer, director, employee, controlling shareholder,
6 or submanager of a manager acting for that insurer. (V.T.I.C. Art.
7 21.07-7, Sec. 8(e).)

8 [Sections 4152.257-4152.300 reserved for expansion]

9 SUBCHAPTER G. DISCIPLINE AND ENFORCEMENT

10 Sec. 4152.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
11 ACTION. The department may deny an application for a license or
12 discipline a license holder under Subchapter C, Chapter 4005, if
13 the department determines that the applicant or license holder, or
14 a person who would be authorized to act on behalf of the applicant
15 or license holder under Section 4152.057, has:

16 (1) wilfully violated or participated in the violation
17 of this chapter or another insurance law of this state;

18 (2) intentionally made a material misstatement in the
19 license application;

20 (3) obtained or attempted to obtain the license by
21 fraud or misrepresentation;

22 (4) misappropriated, converted to the person's own
23 use, or illegally withheld money required to be held in a fiduciary
24 capacity;

25 (5) materially misrepresented the terms or effect of
26 any contract of insurance or reinsurance, or engaged in any
27 fraudulent transaction; or

(6) been convicted of a felony or of a misdemeanor of which criminal fraud is an essential element. (V.T.I.C. Art. 21.07-7, Sec. 3(e).)

Sec. 4152.302. IMPOSITION OF SANCTIONS. (a) The commissioner may impose or seek any sanction authorized by law, including the penalties authorized by Chapters 82 and 83, against a reinsurance intermediary, insurer, or reinsurer who the commissioner determines, after notice and hearing as provided by this code, has violated this chapter.

(b) The commissioner may impose or seek any sanction authorized by law, including the penalties authorized by Chapter 101, against a nonlicensed reinsurance intermediary who violates this chapter. (V.T.I.C. Art. 21.07-7, Sec. 10(a).)

CHAPTER 4153. RISK MANAGERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4153.001. DEFINITION

Sec. 4153.002. EXEMPTIONS

Sec. 4153.003. RULES

[Sections 4153.004-4153.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4153.051. LICENSE REQUIRED

Sec. 4153.052. APPLICATION

Sec. 4153.053. QUALIFICATIONS

Sec. 4153.054. EXAMINATION

Sec. 4153.055. EXEMPTIONS FROM EXAMINATION REQUIREMENT

Sec. 4153.056. REEXAMINATION

Sec. 4153.057. FEES

1 Sec. 4153.058. RECIPROCAL LICENSE

2 Sec. 4153.059. LICENSE EXPIRATION

3 Sec. 4153.060. LICENSE RENEWAL

4 [Sections 4153.061-4153.100 reserved for expansion]

5 SUBCHAPTER C. POWERS AND DUTIES OF RISK MANAGERS

6 Sec. 4153.101. PLACE OF BUSINESS

7 Sec. 4153.102. NOTIFICATION OF CHANGE OF PLACE OF
8 BUSINESS

9 [Sections 4153.103-4153.150 reserved for expansion]

10 SUBCHAPTER D. DISCIPLINARY ACTION

11 Sec. 4153.151. GROUNDS FOR DISCIPLINARY ACTION

12 Sec. 4153.152. LICENSE SUSPENSION

13 Sec. 4153.153. REINSTATEMENT OR REISSUANCE OF LICENSE

14 CHAPTER 4153. RISK MANAGERS

15 SUBCHAPTER A. GENERAL PROVISIONS

16 Sec. 4153.001. DEFINITION. In this chapter, "risk manager"
17 means a person who:

18 (1) represents to the public that the person is a risk
19 manager; and

20 (2) for compensation examines or evaluates risks for
21 and provides advice regarding reduction of risks to a person
22 seeking to obtain or renew property and casualty insurance coverage
23 in this state. (V.T.I.C. Art. 21.14-1, Sec. 1(1).)

24 Sec. 4153.002. EXEMPTIONS. This chapter does not apply to a
25 person who is employed as a risk manager by:

26 (1) a liability insurance company authorized to engage
27 in business in this state;

- 1 (2) a single employer; or
- 2 (3) a public self-insurance pool. (V.T.I.C. Art.
- 3 21.14-1, Sec. 3.)

4 Sec. 4153.003. RULES. The commissioner may adopt rules

5 necessary to carry out this chapter and to regulate risk managers.

6 (V.T.I.C. Art. 21.14-1, Sec. 15.)

7 [Sections 4153.004-4153.050 reserved for expansion]

8 SUBCHAPTER B. LICENSE REQUIREMENTS

9 Sec. 4153.051. LICENSE REQUIRED. A person may not act as or

10 represent that the person is a risk manager in this state unless the

11 person:

12 (1) meets the requirements prescribed by this chapter

13 and department rules; and

14 (2) holds a license issued by the department.

15 (V.T.I.C. Art. 21.14-1, Sec. 2.)

16 Sec. 4153.052. APPLICATION. (a) To obtain a license to act

17 as a risk manager in this state, an applicant must submit to the

18 department an application on forms prescribed by the commissioner

19 and provided by the department.

20 (b) An application must be accompanied by the license fee

21 required by Section 4153.057 and include:

22 (1) information the department requires relating to

23 the applicant's identity, personal history, experience, and

24 business record; and

25 (2) any other information the department requires.

26 (V.T.I.C. Art. 21.14-1, Secs. 4, 7(b).)

27 Sec. 4153.053. QUALIFICATIONS. To qualify for a risk

1 manager's license, an applicant must:

- 2 (1) be at least 18 years of age;
- 3 (2) maintain a place of business in this state;
- 4 (3) meet the application requirements prescribed by
5 this chapter and department rules;
- 6 (4) take and pass the examination required by this
7 chapter; and
- 8 (5) pay the examination and license fees. (V.T.I.C.
9 Art. 21.14-1, Sec. 5.)

10 Sec. 4153.054. EXAMINATION. (a) Except as provided by
11 Sections 4153.055 and 4153.058, an applicant for a risk manager's
12 license must personally take and pass an examination to the
13 satisfaction of the commissioner under this chapter and department
14 rules.

15 (b) The commissioner shall prescribe the examination for a
16 risk manager's license. The examination must:

- 17 (1) be designed to test the qualifications and
18 competency of the applicant to be a risk manager; and
- 19 (2) be of sufficient scope to reasonably test the
20 applicant's knowledge of risk management and the duties and
21 responsibilities of a risk manager under the laws of this state and
22 department rules.

23 (c) The department shall:

- 24 (1) determine the times and places for examinations;
25 and
- 26 (2) give reasonable public notice of the examinations
27 in the manner provided by department rules. (V.T.I.C. Art.

21.14-1, Secs. 6(a), (c), (d), (e).)

Sec. 4153.055. EXEMPTIONS FROM EXAMINATION REQUIREMENT. An applicant is not required to take an examination to obtain a risk manager's license if the applicant holds the designation of:

(1) chartered property casualty underwriter (CPCU) from the American Institute for Chartered Property Casualty Underwriters;

(2) certified insurance counselor (CIC) from the national Society of Certified Insurance Counselors; or

(3) associate in risk management (ARM) from the Insurance Institute of America. (V.T.I.C. Art. 21.14-1, Sec. 6(b).)

Sec. 4153.056. REEXAMINATION. (a) An applicant who fails the examination may retake the examination on payment of an additional examination fee.

(b) The commissioner may require the applicant to wait for a reasonable period determined by the commissioner before the applicant may retake the examination. (V.T.I.C. Art. 21.14-1, Secs. 6(g), (i).)

Sec. 4153.057. FEES. (a) The commissioner shall set and collect in advance a nonrefundable fee, in an amount not to exceed \$50, for:

(1) an examination required by this chapter if the department administers the examination;

(2) a risk manager's license; and

(3) the renewal of a risk manager's license.

(b) A fee collected under this section shall be deposited to

1 the credit of the Texas Department of Insurance operating account.
2 (V.T.I.C. Art. 21.14-1, Secs. 7(a), (c); Sec. 8 (part).)

3 Sec. 4153.058. RECIPROCAL LICENSE. On submission of an
4 application and the license fee required by Section 4153.057, a
5 person may receive a risk manager's license without examination if
6 the person is licensed as a risk manager by another state, the
7 licensing requirements of which were, on the date the license was
8 issued, substantially equivalent to the requirements prescribed by
9 this chapter. (V.T.I.C. Art. 21.14-1, Sec. 13.)

10 Sec. 4153.059. LICENSE EXPIRATION. Except as otherwise
11 provided by a staggered renewal system adopted under Section
12 4003.002, a risk manager's license expires on the second
13 anniversary of the date the license was issued. (V.T.I.C. Art.
14 21.14-1, Sec. 8 (part).)

15 Sec. 4153.060. LICENSE RENEWAL. (a) A license holder may
16 renew an unexpired license by:

17 (1) filing with the department a completed renewal
18 application; and

19 (2) paying the nonrefundable renewal fee.

20 (b) The commissioner shall issue a renewal certificate to
21 the license holder if the commissioner determines the license
22 holder continues to be eligible for the license. (V.T.I.C. Art.
23 21.14-1, Sec. 8 (part).)

24 [Sections 4153.061-4153.100 reserved for expansion]

25 SUBCHAPTER C. POWERS AND DUTIES OF RISK MANAGERS

26 Sec. 4153.101. PLACE OF BUSINESS. A license holder shall
27 maintain a place of business in this state that is:

(1) accessible to the public; and

(2) located at the place at which the license holder principally conducts business. (V.T.I.C. Art. 21.14-1, Sec. 9 (part).)

Sec. 4153.102. NOTIFICATION OF CHANGE OF PLACE OF BUSINESS.

A license holder who changes the address of the license holder's place of business from the address that appears on the license shall notify the department of that change as provided by department rules. (V.T.I.C. Art. 21.14-1, Sec. 9 (part).)

[Sections 4153.103-4153.150 reserved for expansion]

SUBCHAPTER D. DISCIPLINARY ACTION

Sec. 4153.151. GROUNDS FOR DISCIPLINARY ACTION. The department may discipline a license holder or deny an applicant a license under Subchapter C, Chapter 4005:

(1) for any cause for which, if known by the department, issuance of the license could have been refused; or

(2) if the license holder or applicant:

(A) wilfully or knowingly violates this chapter, an insurance law of this state, or a department rule;

(B) obtains or attempts to obtain a license through wilful misrepresentation or fraud;

(C) fails the examination required by this chapter; or

(D) is convicted on final judgment of a felony. (V.T.I.C. Art. 21.14-1, Sec. 10.)

Sec. 4153.152. LICENSE SUSPENSION. (a) An order suspending a license must specify the duration of the suspension

1 period. The department may not suspend a license for a period of
2 more than 12 months.

3 (b) A license holder whose license is revoked or suspended
4 shall surrender the license to the commissioner at the
5 commissioner's request. (V.T.I.C. Art. 21.14-1, Sec. 11.)

6 Sec. 4153.153. REINSTATEMENT OR REISSUANCE OF LICENSE. The
7 commissioner may not reinstate the license of or reissue a license
8 to a person whose license is suspended or revoked or to whom the
9 department refuses to issue a renewal certificate until the first
10 anniversary of the date of the suspension, revocation, or refusal
11 to renew. (V.T.I.C. Art. 21.14-1, Sec. 12.)

12 SECTION 8. CONFORMING AMENDMENT. Article 1.10, Insurance
13 Code, is amended to read as follows:

14 Art. 1.10. CERTAIN DUTIES OF THE DEPARTMENT. In addition to
15 the other duties required of the department, the department shall
16 perform duties as follows:

17 2. File Articles of Incorporation and Other Papers.
18 File and preserve in its office all acts or articles of
19 incorporation of insurance companies and all other papers required
20 by law to be deposited with the Department and, upon application of
21 any party interested therein, furnish certified copies thereof upon
22 payment of the fees prescribed by law.

23 3. Shall Calculate Reserve. For every company
24 transacting any kind of insurance business in this State, for which
25 no basis is prescribed by law, the Department shall calculate the
26 reinsurance reserve upon the same basis prescribed in Section
27 862.102 of this code as to companies transacting fire insurance

1 business.

2 4. To Calculate Re-insurance Reserve. On the
3 thirty-first day of December of each and every year, or as soon
4 thereafter as may be practicable, the Department shall have
5 calculated in the Department the re-insurance reserve for all
6 unexpired risks of all insurance companies organized under the laws
7 of this state, or transacting business in this state, transacting
8 any kind of insurance other than life, fire, marine, inland,
9 lightning or tornado insurance, which calculation shall be in
10 accordance with the provisions of Paragraph 3 hereof.

11 5. When a Company's Surplus is Impaired. No impairment
12 of the capital stock of a stock company shall be permitted. No
13 impairment of the surplus of a stock company, or of the minimum
14 required aggregate surplus of a mutual, Lloyd's, or reciprocal
15 insurer, shall be permitted in excess of that provided by this
16 section. Having charged against a company other than a life
17 insurance company, the reinsurance reserve, as prescribed by the
18 laws of this State, and adding thereto all other debts and claims
19 against the company, the Commissioner shall, (i) if it is
20 determined that the surplus required by Section 822.054, 822.202,
21 822.203, 822.205, 822.210, 822.211, or 822.212 of this code of a
22 stock company doing the kind or kinds of insurance business set out
23 in its Certificate of Authority is impaired to the extent of more
24 than fifty (50%) per cent of the required surplus for a capital
25 stock insurance company, or is less than the minimum level of
26 surplus required by Commissioner promulgated risk-based capital
27 and surplus regulations, or (ii) if it is determined that the

1 required aggregate surplus of a reciprocal or mutual company, or
2 the required aggregate of guaranty fund and surplus of a Lloyd's
3 company, other than a life insurance company, doing the kind or
4 kinds of insurance business set out in its Certificate of Authority
5 is impaired to the extent of more than twenty-five per cent (25%) of
6 the required aggregate surplus, or is less than the minimum level of
7 surplus required by Commissioner promulgated risk-based capital
8 and surplus regulations, the Commissioner shall order the company
9 to remedy the impairment of surplus to acceptable levels specified
10 by the Commissioner or to cease to do business within this State.
11 The Commissioner shall thereupon immediately institute such
12 proceedings as may be necessary to determine what further actions
13 shall be taken in the case.

14 6. Shall Publish Results of Investigation. The
15 Department shall publish the result of an examination of the
16 affairs of any company whenever the Commissioner deems it for the
17 interest of the public.

18 17. Voluntary Deposits. (a) In the event any
19 insurance company organized and doing business under the provisions
20 of this Code shall be required by any other state, country or
21 province as a requirement for permission to do an insurance
22 business therein to make or maintain a deposit with an officer of
23 any state, country, or province, such company, at its discretion,
24 may voluntarily deposit with the Comptroller such securities as may
25 be approved by the Commissioner of Insurance to be of the type and
26 character authorized by law to be legal investments for such
27 company, or cash, in any amount sufficient to enable it to meet such

1 requirements. The Comptroller is hereby authorized and directed to
2 receive such deposit and hold it exclusively for the protection of
3 all policyholders or creditors of the company wherever they may be
4 located, or for the protection of the policyholders or creditors of
5 a particular state, country or province, as may be designated by
6 such company at the time of making such deposit. The company may,
7 at its option, withdraw such deposit or any part thereof, first
8 having deposited with the Comptroller, in lieu thereof, other
9 securities of like class and of equal amount and value to those
10 withdrawn, which withdrawal and substitution must be approved by
11 the Commissioner of Insurance. The proper officer of each
12 insurance company making such deposit shall be permitted at all
13 reasonable times to examine such securities and to detach coupons
14 therefrom, and to collect interest thereon, under such reasonable
15 rules and regulations as may be prescribed by the Comptroller and
16 the Commissioner of Insurance. Any deposit so made for the
17 protection of policyholders or creditors of a particular state,
18 country or province shall not be withdrawn, except by substitution
19 as provided above, by the company, except upon filing with the
20 Commissioner of Insurance evidence satisfactory to him that the
21 company has withdrawn from business, and has no unsecured
22 liabilities outstanding or potential policyholder liabilities or
23 obligations in such other state, country or province requiring such
24 deposit, and upon the filing of such evidence the company may
25 withdraw such deposit at any time upon the approval of the
26 Commissioner of Insurance. Any deposit so made for the protection
27 of all policyholders or creditors wherever they may be located

1 shall not be withdrawn, except by substitution as provided above,
2 by the company except upon filing with the Commissioner of
3 Insurance evidence satisfactory to him that the company does not
4 have any unsecured liabilities outstanding or potential policy
5 liabilities or obligations anywhere, and upon filing such evidence
6 the company may withdraw such deposit upon the approval of the
7 Commissioner of Insurance. For the purpose of state, county and
8 municipal taxation, the situs of any securities deposited with the
9 Comptroller hereunder shall be in the city and county where the
10 principal business office of such company is fixed by its charter.

11 (b) Any voluntary deposit held by the Comptroller or
12 the Department heretofore made by any insurance company in this
13 State, and which deposit was made for the purpose of gaining
14 admission to another state, may be considered, at the option of such
15 company, to be hereinafter held under the provisions of this Act.

16 (c) When two or more companies merge or consolidate or
17 enter a total reinsurance contract by which the ceding company is
18 dissolved and its assets acquired and liabilities assumed by the
19 surviving company, and the companies have on deposit with the
20 Comptroller two or more deposits made for identical purposes under
21 this section or Article 4739, Revised Statutes, as amended, and now
22 repealed, all such deposits, except the deposit of greatest amount
23 and value, may be withdrawn by the new surviving or reinsuring
24 company, upon proper showing of duplication of such deposits and
25 that the company is the owner thereof.

26 (d) Any company which has made a deposit or deposits
27 under this section or Article 4739, Revised Statutes, as amended

1 and now repealed, shall be entitled to a return of such deposits
2 upon proper application therefor and a showing before the
3 Commissioner that such deposit or deposits are no longer required
4 under the laws of any state, country or province in which such
5 company sought or gained admission to do business upon the strength
6 of a certificate of such deposit.

7 (e) Upon being furnished a certified copy of the
8 Commissioner's order issued under Subsection (c) or (d) above, the
9 Comptroller shall release, transfer and deliver such deposit or
10 deposits to the owner as directed in said order.

11 ~~[18. Complaint File. The Department shall keep an~~
12 ~~information file about each complaint filed with the Department~~
13 ~~concerning an activity that is regulated by the Department or~~
14 ~~Commissioner.]~~

15 ~~[19. Notice of Complaint Status. If a written~~
16 ~~complaint is filed with the Department, the Department, at least~~
17 ~~quarterly and until final disposition of the complaint, shall~~
18 ~~notify the parties to the complaint of the status of the complaint~~
19 ~~unless the notice would jeopardize an undercover investigation.]~~

20 ~~[20. Electronic Transfer of Funds. The Commissioner~~
21 ~~shall adopt rules for the electronic transfer of any taxes, fees,~~
22 ~~guarantee funds, or other money owed to or held for the benefit of~~
23 ~~the state and for which the Department has the responsibility to~~
24 ~~administer under this code or another insurance law of this state.~~
25 ~~The Commissioner shall require the electronic transfer of any~~
26 ~~amounts held or owed in an amount exceeding \$500,000.]~~

27 SECTION 9. CONFORMING AMENDMENT. Chapter 30, Insurance

Code, is amended to read as follows:

CHAPTER 30. GENERAL PROVISIONS

Sec. 30.001. PURPOSE OF TITLES 2, 3, 5, 6, 7, [AND] 8, 9, 11, AND 13. (a) This title and Titles 3, 5, 6, 7, [and] 8, 9, 11, and 13 are enacted as a part of the state's continuing statutory revision program, begun by the Texas Legislative Council in 1963 as directed by the legislature in the law codified as Section 323.007, Government Code. The program contemplates a topic-by-topic revision of the state's general and permanent statute law without substantive change.

(b) Consistent with the objectives of the statutory revision program, the purpose of this title and Titles 3, 5, 6, 7, [and] 8, 9, 11, and 13 is to make the law encompassed by the titles more accessible and understandable by:

(1) rearranging the statutes into a more logical order;

(2) employing a format and numbering system designed to facilitate citation of the law and to accommodate future expansion of the law;

(3) eliminating repealed, duplicative, unconstitutional, expired, executed, and other ineffective provisions; and

(4) restating the law in modern American English to the greatest extent possible.

Sec. 30.002. CONSTRUCTION. Except as provided by Section 30.003 and as otherwise expressly provided in this code, Chapter 311, Government Code (Code Construction Act), applies to the

1 construction of each provision in this title and in Titles 3, 5, 6,
2 7, [~~and~~] 8, 9, 11, and 13.

3 Sec. 30.003. DEFINITION OF PERSON. The definition of
4 "person" assigned by Section 311.005, Government Code, does not
5 apply to any provision in this title or in Title 3, 5, 6, 7, [~~or~~] 8,
6 9, 11, or 13.

7 Sec. 30.004. REFERENCE IN LAW TO STATUTE REVISED BY TITLE 2,
8 3, 5, 6, 7, [~~OR~~] 8, 9, 11, OR 13. A reference in a law to a statute
9 or a part of a statute revised by this title or by Title 3, 5, 6, 7,
10 [~~or~~] 8, 9, 11, or 13 is considered to be a reference to the part of
11 this code that revises that statute or part of that statute.

12 SECTION 10. CONFORMING AMENDMENT. Subchapter B, Chapter
13 36, Insurance Code, is amended by adding Section 36.108 to read as
14 follows:

15 Sec. 36.108. FILING DATE OF REPORT, FINANCIAL STATEMENT, OR
16 PAYMENT DELIVERED BY POSTAL SERVICE. Except as otherwise
17 specifically provided, for a report, financial statement, or
18 payment that is required to be filed or made in the offices of the
19 commissioner and that is delivered by the United States Postal
20 Service to the offices of the commissioner after the date on which
21 the report, financial statement, or payment is required to be filed
22 or made, the date of filing or payment is the date of:

23 (1) the postal service postmark stamped on the cover
24 in which the report, financial statement, or payment is mailed; or

25 (2) any other evidence of mailing authorized by the
26 postal service reflected on the cover in which the report,
27 financial statement, or payment is mailed. (V.T.I.C. Art. 1.11

(part), as amended Acts 77th Leg., R.S., Ch. 1419.)

SECTION 11. CONFORMING AMENDMENT. Subchapter B, Chapter 36, Insurance Code, is amended by adding Section 36.109 to read as follows:

Sec. 36.109. RENEWAL EXTENSION FOR CERTAIN PERSONS PERFORMING MILITARY SERVICE. (a) The department may extend the renewal period for a license, permit, certificate of authority, certificate of registration, or other authorization issued by the department to engage in an activity regulated under this code or other insurance laws of this state for a person who is unable in a timely manner to comply with renewal requirements, including any applicable continuing education requirements, because the person was on active duty in a combat theater of operations in the United States armed forces.

(b) A person must submit a written application for an extension under this section to the department.

(c) The department shall exempt a person who receives an extension under this section from any increased fee or other penalty otherwise imposed for failure to renew in a timely manner.

(d) The commissioner may adopt rules as necessary to implement this section. (V.T.I.C. Art. 1.10-1.)

SECTION 12. CONFORMING AMENDMENT. Subchapter B, Chapter 37, Insurance Code, is amended by adding Section 37.053 to read as follows:

Sec. 37.053. EFFECTIVENESS OF RATE DURING APPEAL. (a) An order of the commissioner that determines, approves, or sets a rate under this code and that is appealed remains in effect during the

1 pendency of the appeal. An insurer shall use the rate provided in
2 the order while the appeal is pending.

3 (b) The rate is lawful and valid during the appeal, and an
4 insurer may not be required to make any refund from that rate after
5 a decision on the appeal is rendered.

6 (c) If the order is vacated on appeal, the rate established
7 by the commissioner before the vacated order was rendered remains
8 in effect from the date of remand until the commissioner makes a
9 further determination. The commissioner shall consider the court's
10 order in setting a future rate. (V.T.I.C. Art. 1.35A, Sec. 5(d).)

11 SECTION 13. CONFORMING AMENDMENT. Section 101.053(b),
12 Insurance Code, is amended to read as follows:

13 (b) Sections 101.051 and 101.052 do not apply to:

14 (1) the lawful transaction of surplus lines insurance
15 under Chapter 981;

16 (2) the lawful transaction of reinsurance by insurers;

17 (3) a transaction in this state that:

18 (A) involves a policy that:

19 (i) is lawfully solicited, written, and
20 delivered outside this state; and

21 (ii) covers, at the time the policy is
22 issued, only subjects of insurance that are not resident, located,
23 or expressly to be performed in this state; and

24 (B) takes place after the policy is issued;

25 (4) a transaction:

26 (A) that involves an insurance contract
27 independently procured through negotiations occurring entirely

1 outside this state;

2 (B) that is reported; and

3 (C) on which premium tax is paid in accordance
4 with Chapter 226 [~~this chapter~~];

5 (5) a transaction in this state that:

6 (A) involves group life, health, or accident
7 insurance, other than credit insurance, and group annuities in
8 which the master policy for the group was lawfully issued and
9 delivered in a state in which the insurer or person was authorized
10 to do insurance business; and

11 (B) is authorized by a statute of this state;

12 (6) an activity in this state by or on the sole behalf
13 of a nonadmitted captive insurance company that insures solely:

14 (A) directors' and officers' liability insurance
15 for the directors and officers of the company's parent and
16 affiliated companies;

17 (B) the risks of the company's parent and
18 affiliated companies; or

19 (C) both the individuals and entities described
20 by Paragraphs (A) and (B);

21 (7) the issuance of a qualified charitable gift
22 annuity under Chapter 102; or

23 (8) a lawful transaction by a servicing company of the
24 Texas workers' compensation employers' rejected risk fund under
25 Section 4.08, Article 5.76-2, as that article existed before its
26 repeal.

27 SECTION 14. CONFORMING AMENDMENT. Section 101.103(a),

Insurance Code, is amended to read as follows:

(a) If the commissioner has reason to believe a person, including an insurer, has violated or is threatening to violate this chapter or Chapter 226 or a rule adopted under this chapter or Chapter 226, or that a person, including an insurer, violating this chapter or Chapter 226 has engaged in or is threatening to engage in an unfair act, the commissioner may:

- (1) issue a cease and desist order under Subchapter D;
- (2) seek injunctive relief under Section 101.105;
- (3) request the attorney general to recover a civil penalty under Section 101.105; or
- (4) take any combination of those actions.

SECTION 15. CONFORMING AMENDMENT. Sections 101.105(a) and (b), Insurance Code, are amended to read as follows:

(a) A person or entity, including an insurer, that violates this chapter or Chapter 226 is subject to a civil penalty of not more than \$10,000 for each act of violation and for each day of violation.

(b) The commissioner may request that the attorney general institute a civil suit in a district court in Travis County for injunctive relief to restrain a person or entity, including an insurer, from continuing a violation or threat of violation described by Section 101.103(a). On application for injunctive relief and a finding that a person or entity, including an insurer, is violating or threatening to violate this chapter or Chapter 226, the district court shall grant the injunctive relief and issue an injunction without bond.

SECTION 16. CONFORMING AMENDMENT. Section 101.201(b), Insurance Code, is amended to read as follows:

(b) This section does not apply to insurance procured by a licensed surplus lines agent from an eligible surplus lines insurer as defined by Chapter 981 [~~Article 1.14-2~~] and independently procured contracts of insurance, as described in Section 101.053(b)(4), that are reported and on which premium tax is paid in accordance with Chapter 225 or 226 [~~this chapter or Article 1.14-2~~].

SECTION 17. CONFORMING AMENDMENT. Subchapter C, Chapter 841, Insurance Code, is amended by adding Section 841.104 to read as follows:

Sec. 841.104. TAX PAYMENT REQUIRED FOR ISSUANCE OF CERTAIN CERTIFICATES OF AUTHORITY. (a) This section applies to a life insurance company that:

(1) has previously held a certificate of authority to engage in the business of life insurance in this state;

(2) ceased to write new business in this state under that certificate of authority; and

(3) after ceasing to write new business, continued to collect from residents of this state renewal or other premiums on policies written under that certificate of authority.

(b) A life insurance company to which this section applies may not obtain a new certificate of authority to engage in the business of life insurance in this state until the company:

(1) files with the department under oath a report that discloses the gross amount of renewal or other premiums received

1 each calendar year from residents of this state after the period
2 covered by the company's last tax report of gross premium receipts
3 filed under this code; and

4 (2) pays to the state occupation taxes on those
5 premiums.

6 (c) The life insurance company shall pay the occupation tax
7 for each year of nonpayment. The company shall pay the tax for each
8 year at the same rate for that year as a company engaged in the
9 business of life insurance in this state during that year.

10 (d) The life insurance company shall remit the penalties for
11 failure to pay the taxes and file required reports when the company
12 pays the taxes and receives a certificate of authority. (V.T.I.C.
13 Art. 3.59.)

14 SECTION 18. CONFORMING AMENDMENT. The heading to
15 Subchapter C, Chapter 982, Insurance Code, is amended to read as
16 follows:

17 SUBCHAPTER C. ~~[REQUIREMENTS FOR]~~ CERTIFICATE OF AUTHORITY

18 SECTION 19. CONFORMING AMENDMENT. Subchapter C, Chapter
19 982, Insurance Code, is amended by adding Section 982.114 to read as
20 follows:

21 Sec. 982.114. PAYMENT OF TAX BY FOREIGN OR ALIEN LIFE
22 INSURANCE COMPANY. (a) A foreign or alien life insurance company
23 that obtains a certificate of authority under this subchapter on or
24 after April 2, 1909, accepts that certificate and agrees to engage
25 in the business of insurance in this state subject to a requirement
26 that, if the company ceases to transact new insurance business in
27 this state but continues to collect renewal premiums from residents

1 of this state, the company shall continue to pay an occupation tax
2 based on gross premiums for each year from residents of this state.

3 (b) The rate of the tax imposed by this section may not
4 exceed the rate imposed by law on insurance companies transacting
5 new insurance business in this state.

6 (c) The foreign or alien life insurance company shall pay
7 the tax and make reports relating to its gross premium receipts in
8 the same manner as a foreign or alien life insurance company that is
9 transacting new insurance business in this state.

10 (d) The foreign or alien life insurance company is subject
11 to examination by the department or by a department designee in the
12 same manner and to the same extent as a company that is transacting
13 new insurance business in this state. (V.T.I.C. Art. 3.25 (part).)

14 SECTION 20. CONFORMING AMENDMENT. Section 181.051, Health
15 and Safety Code, is amended to read as follows:

16 Sec. 181.051. PARTIAL EXEMPTION. Except for Subchapter D,
17 this chapter does not apply to:

18 (1) a covered entity as defined by Section 602.001
19 [~~licensee as defined in Article 28B.01~~], Insurance Code;

20 (2) an entity established under Article 5.76-3,
21 Insurance Code; or

22 (3) an employer.

23 SECTION 21. CONFORMING AMENDMENT. Section 403.002(b),
24 Labor Code, is amended to read as follows:

25 (b) The assessment may not exceed an amount equal to two
26 percent of the correctly reported gross workers' compensation
27 insurance premiums, including the modified annual premium of a

1 policyholder that purchases an optional deductible plan under
2 Article 5.55C, Insurance Code. The rate of assessment shall be
3 applied to the modified annual premium before application of a
4 deductible premium credit. (V.T.I.C. Art. 5.68, Sec. (b) (part).)

5 SECTION 22. CONFORMING AMENDMENT. Subtitle A, Title 3,
6 Occupations Code, is amended by adding Chapter 107 to read as
7 follows:

8 CHAPTER 107. TELEMEDICINE AND TELEHEALTH

9 Sec. 107.001. DEFINITIONS. In this chapter:

10 (1) "Health professional" and "physician" have the
11 meanings assigned by Section 1455.001, Insurance Code.

12 (2) "Telehealth service" and "telemedicine medical
13 service" have the meanings assigned by Section 57.042, Utilities
14 Code. (V.T.I.C. Art. 21.53F, Secs. 1(2), (3), (4), (5), as added
15 Acts 75th Leg., R.S., Ch. 880.)

16 Sec. 107.002. INFORMED CONSENT. A treating physician or
17 health professional who provides or facilitates the use of
18 telemedicine medical services or telehealth services shall ensure
19 that the informed consent of the patient, or another appropriate
20 individual authorized to make health care treatment decisions for
21 the patient, is obtained before telemedicine medical services or
22 telehealth services are provided. (V.T.I.C. Art. 21.53F, Sec. 4,
23 as added Acts 75th Leg., R.S., Ch. 880.)

24 Sec. 107.003. CONFIDENTIALITY. A treating physician or
25 health professional who provides or facilitates the use of
26 telemedicine medical services or telehealth services shall ensure
27 that the confidentiality of the patient's medical information is

1 maintained as required by Chapter 159 or other applicable law.
2 (V.T.I.C. Art. 21.53F, Sec. 5, as added Acts 75th Leg., R.S., Ch.
3 880.)

4 Sec. 107.004. RULES. The Texas State Board of Medical
5 Examiners, in consultation with the commissioner of insurance, as
6 appropriate, may adopt rules necessary to:

7 (1) ensure that patients using telemedicine medical
8 services receive appropriate, quality care;

9 (2) prevent abuse and fraud in the use of telemedicine
10 medical services, including rules relating to the filing of claims
11 and records required to be maintained in connection with
12 telemedicine medical services;

13 (3) ensure adequate supervision of health
14 professionals who are not physicians and who provide telemedicine
15 medical services;

16 (4) establish the maximum number of health
17 professionals who are not physicians that a physician may supervise
18 through a telemedicine medical service; and

19 (5) require a face-to-face consultation between a
20 patient and a physician providing a telemedicine medical service
21 within a certain number of days following an initial telemedicine
22 medical service only if the physician has never seen the patient.

23 (V.T.I.C. Art. 21.53F, Sec. 6(b), as added Acts 75th Leg., R.S., Ch.
24 880.)

25 SECTION 23. CONFORMING AMENDMENT. Subchapter B, Chapter
26 171, Tax Code, is amended by adding Section 171.0525 to read as
27 follows:

1 Sec. 171.0525. EXEMPTION--CERTAIN INSURANCE COMPANIES. A
2 corporation that is a farm mutual insurance company, local mutual
3 aid association, or burial association is exempted from the
4 franchise tax. (V.T.I.C. Art. 4.10, Sec. 14.)

5 SECTION 24. CONFORMING AMENDMENT. Subchapter B, Chapter
6 171, Tax Code, is amended by adding Section 171.0527 to read as
7 follows:

8 Sec. 171.0527. EXEMPTION--TITLE INSURANCE COMPANIES AND
9 TITLE INSURANCE AGENTS. (a) In this section, "title insurance
10 company" and "title insurance agent" have the meanings assigned by
11 Section 2501.003, Insurance Code.

12 (b) A corporation that is a title insurance company or title
13 insurance agent whose principal activity is the business of title
14 insurance as described by Section 2501.005, Insurance Code, is
15 exempted from the franchise tax. (V.T.I.C. Art. 9.59, Sec. 16(d)
16 (part); (New).)

17 SECTION 25. CONFORMING AMENDMENT. Chapter 171, Tax Code,
18 is amended by adding Subchapter U to read as follows:

19 SUBCHAPTER U. TAX CREDIT FOR CERTAIN PREMIUM TAXES

20 Sec. 171.891. APPLICABILITY OF DEFINITIONS. In this
21 subchapter:

22 (1) "Control" has the meaning described by Sections
23 823.005 and 823.151, Insurance Code.

24 (2) "Controlled insurer," "domestic insurer," and
25 "holding company" have the meanings assigned by Section 823.002,
26 Insurance Code.

27 (3) "Title insurance," "title insurance agent," and

1 "title insurance company" have the meanings assigned by Section
2 2501.003, Insurance Code. (V.T.I.C. Art. 9.59, Sec. 16(a); (New).)

3 Sec. 171.892. ELIGIBILITY. A corporation is entitled to a
4 credit as provided by this subchapter against the tax imposed under
5 this chapter if the corporation:

6 (1) is a title insurance holding company subject to
7 Chapter 823, Insurance Code; and

8 (2) controls one or more domestic title insurance
9 companies that are subject to the tax on premiums imposed under
10 Chapter 223, Insurance Code. (V.T.I.C. Art. 9.59, Sec. 16(b)
11 (part).)

12 Sec. 171.893. AMOUNT; LIMITATIONS. (a) The amount of the
13 credit for each controlled domestic title insurance company is
14 computed by multiplying the amount of tax on premiums paid by that
15 company in the most recent calendar year ending before the
16 franchise tax report is due by the percentage ownership of the title
17 insurance holding company in the controlled domestic title
18 insurance company. The percentage of ownership of a controlled
19 domestic title insurance company is determined as of the accounting
20 year-end on which the report is based.

21 (b) The total credit claimed under this subchapter may not
22 exceed the amount of tax due for the report.

23 (c) A corporation may not carry a credit forward or backward
24 to apply the credit to another year's report. (V.T.I.C. Art. 9.59,
25 Secs. 16(b) (part), (c).)

26 Sec. 171.894. EFFECT ON OTHER TAXES. This subchapter does
27 not exempt a title insurance holding company, title insurance

company, or title insurance agent from another tax imposed under this code. (V.T.I.C. Art. 9.59, Sec. 16(d) (part).)

SECTION 26. REPEALER. (a) The following Acts and articles as compiled in Vernon's Texas Insurance Code are repealed:

(1) 1.04B, 1.10C, 1.10D, 1.10-1, 1.11, 1.14-2, 1.20, 1.21, 1.22, 1.31, 1.31A, 1.31B, 1.35, 1.35A, 1.35B, 1.35D, 1.35E, 1.37, 3.25, 3.42, 3.42B, 3.42-1, 3.51-5A, 3.51-6, 3.51-6A, 3.51-6B, 3.51-6C, 3.51-6D, 3.51-8, 3.51-9, 3.51-10, 3.51-12, 3.51-13, 3.51-14, 3.59, 3.64, 3.70-1, 3.70-1A, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, 3.70-11, 3.70-12, 3.70-13, 3.71, 3.72, 3.74, 3.76, 3.77, 3.78, 3.79, 4.02, 4.03, 4.04, 4.05, 4.06, 4.07, 4.10, 4.11, 4.11B, 4.11C, 4.12, 4.17, 4.18, 4.19, 5.12, 5.24, 5.49, 5.68, 5.91, 20A.01A, 20A.01B, 20A.02, 20A.09B, 20A.09E, 20A.09F, 20A.09Y, 20A.09Z, 20A.18C, 20A.18E, 20A.18F, 20A.18G, 20A.33, 20A.39, 21.01, 21.01-1, 21.01-2, 21.02, 21.03, 21.04, 21.07, 21.07-2, 21.07-3, 21.07-4, 21.07-6, 21.07-7, 21.08, 21.09, 21.10, 21.11, 21.11-1, 21.12, 21.14, 21.14-1, 21.14-2, 21.15-1, 21.15-5, 21.15-6, 21.16, 21.17, 21.18, 21.19, 21.20, 21.21, 21.21A, 21.21B, 21.21-1, 21.21-2, 21.21-4, 21.21-5, 21.21-7, 21.21-8, 21.24-1, 21.24-2, 21.24-3, 21.29, 21.35, 21.35A, 21.35B, 21.36, 21.46, 21.48, 21.48A, 21.48B, 21.49-2, 21.49-2A, 21.49-2B, 21.49-2D, 21.49-2E, 21.49-9, 21.49-10, 21.49-12, 21.49-19, 21.52, 21.52A, 21.52B, 21.52C, 21.52D, 21.52J, 21.52K, 21.53, 21.53A, 21.53B, 21.53C, 21.53G, 21.53I, 21.53K, 21.53L, 21.53M, 21.53N, 21.53Q, 21.53S, 21.53W, 21.55, 21.56, 21.57, 21.58, 21.58D, 21.59, 21.60, 21.71, 21.73, 21.74, 21.78, 21.79D, 21.79F, 21.79G, and 23.08A;

1 (2) 3.70-3C, as added by Chapter 1024, Acts of the 75th
2 Legislature, Regular Session, 1997;

3 (3) 3.70-3C, as added by Chapter 1260, Acts of the 75th
4 Legislature, Regular Session, 1997;

5 (4) 20A.09, as amended by Chapters 163, 837, 905,
6 1023, and 1026, Acts of the 75th Legislature, Regular Session,
7 1997;

8 (5) 20A.09H, as redesignated and amended by Chapter
9 396, Acts of the 77th Legislature, Regular Session, 2001;

10 (6) 20A.09H, as redesignated and amended by Chapter
11 1027, Acts of the 77th Legislature, Regular Session, 2001;

12 (7) 20A.18D, as added by Chapter 550, Acts of the 77th
13 Legislature, Regular Session, 2001;

14 (8) 21.07-1, as added by Chapter 213, Acts of the 54th
15 Legislature, Regular Session, 1955;

16 (9) 21.07-1, as added by Chapter 703, Acts of the 77th
17 Legislature, Regular Session, 2001;

18 (10) 21.21-6, as added by Chapter 415, Acts of the 74th
19 Legislature, Regular Session, 1995;

20 (11) 21.21-6, as added by Chapter 522, Acts of the 74th
21 Legislature, Regular Session, 1995;

22 (12) 21.21-9, as added by Chapter 596, Acts of the 75th
23 Legislature, Regular Session, 1997;

24 (13) 21.21-9, as added by Chapter 1007, Acts of the
25 75th Legislature, Regular Session, 1997;

26 (14) 21.52G, as added by Chapter 725, Acts of the 75th
27 Legislature, Regular Session, 1997;

1 (15) 21.52G, as added by Chapter 955, Acts of the 75th
2 Legislature, Regular Session, 1997;

3 (16) 21.52L, as added by Chapter 1074, Acts of the 77th
4 Legislature, Regular Session, 2001;

5 (17) 21.52L, as added by Chapter 1106, Acts of the 77th
6 Legislature, Regular Session, 2001;

7 (18) 21.53D, as added by Chapter 912, Acts of the 75th
8 Legislature, Regular Session, 1997;

9 (19) 21.53D, as added by Chapter 1285, Acts of the 75th
10 Legislature, Regular Session, 1997;

11 (20) 21.53F, as added by Chapter 683, Acts of the 75th
12 Legislature, Regular Session, 1997;

13 (21) 21.53F, as added by Chapter 832, Acts of the 75th
14 Legislature, Regular Session, 1997;

15 (22) 21.53F, as added by Chapter 880, Acts of the 75th
16 Legislature, Regular Session, 1997; and

17 (23) 21.53F, as added by Chapter 1287, Acts of the 75th
18 Legislature, Regular Session, 1997.

19 (b) The following laws are repealed:

20 (1) Subsections (a), (c), and (d), Article 1.04D,
21 Insurance Code;

22 (2) Section 8, Article 1.14-3, Insurance Code;

23 (3) Subchapters J and K, Chapter 3, Insurance Code;

24 (4) Chapters 9, 24, 26, 27, 28A, and 28B, Insurance
25 Code;

26 (5) Subchapter F, Chapter 101, Insurance Code; and

27 (6) Article 9031, Revised Statutes.

1 SECTION 27. LEGISLATIVE INTENT. This Act is enacted under
2 Section 43, Article III, Texas Constitution. This Act is intended
3 as a recodification only, and no substantive change in law is
4 intended by this Act.

5 SECTION 28. EFFECTIVE DATE. This Act takes effect April 1,
6 2005.